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Accent on Vacation

Average reading time — 4 min. 6 sec.

MIRACLE WORD! The dictionary prosaically defines it as "cessation from work," but in the mind of each of us vacation-time means so much more. At the mere mention of the word, vistas of all the things we would like to do stretch out before us. Torrents of sunshine pouring on foreign soil—surf pounding on the beaten sand—tall timbers and cool lakes in the high mountains—travel by sea, by land, by air—old clothes to laze around in—new clothes to swank around in—tennis, fishing, swimming, camping—HOLIDAYS!

Let us go back to the dictionary's definition for a moment—"cessation from work." The first step in enjoying a good vacation is to include a brief period at the beginning when we can give ourselves time to relax. Even a day or two, when we do absolutely nothing, will start the recreating process that is so essential a part of a real holiday. The old adage that "a change is as good as a rest" is only partially true. If we are going to drive ourselves as hard on our vacation as we have to all year long at our work, there will be no feeling of refreshment. We will come back to our jobs feeling weary—certainly a poor start for eleven months of steady effort. So, relax! Get all the twists and kinks out of your system.

Most Canadian nurses have four weeks of vacation. A few find that they can stretch that period by adding on the occasional long week-end. Some just stretch their holidays into

Going places . . .

and doing . . .

longer periods without much regard for the demands of their organization or staff. This becomes a serious problem in many hospitals where the sick have to be cared for irregardless of the season of the year. So let us not be selfish and demand two or three months off duty. Some one else will just have to work that much harder to fill the void we have created.

Where are you going for your holidays? A hundred or so nurses registered to attend the I.C.N. Conference in Stockholm. Some went as the representatives of associations. Many went on their own and planned to include sightseeing in a variety of European countries. We were delighted to hear of at least one student nurse who was sent. What a galaxy of nursing leaders they saw and heard! What a host of new experiences were theirs as they visited countries and cities and shrines which have hitherto been only names! For those who have been overseas before there was the joy of revisiting familiar haunts—of glad reunions. We hope you are having a grand holiday, all of you travellers to distant parts.

Where are you going for your holidays? Wherever it is, may happiness go with you. Steer clear of the poison ivy patch. Remember all you've heard about the risks of second degree burns when you are working up a good suntan. If you cannot swim, this might be a good summer to learn. Certainly, every nurse should know how to swim.

We trust you have planned for the kind of vacation that will give you the fun which restores self-confidence and releases your creative effort and your leadership for the future.

The end of holidays—the "back to work" doesn't sound nearly so interesting. But a vacation happily spent will ensure a sturdy well-being that will carry us through next winter. Long after the tan has faded there will be glad memories of our holidays in 1949.

Happy holidays to everyone!

things.

Information Wanted!

Anyone knowing the whereabouts of **Josephine Montero,** who is believed to be a nurse practising in Canada, is asked to communicate with: Mr. Sanchez Diego, Immigration Bldg., Quebec City, Que.

* * *

The Canadian Red Cross Society is seeking information regarding a German-born nurse whose maiden name was **Frida Lukau.** She came to Canada in 1930 and when last heard from in 1939 was residing in Vancouver. Enquiry is being made on behalf of a cousin. Send any information to Miss Lavina Johnson, director, National Enquiry Bureau, 95 Wellesley St. E., Toronto 5, Ont.

Minor Disorders in Infancy

HOWARD H. MCGARRY, M.D.

Average reading time — 15 min. 48 sec.

TODAY, serious nutritional and digestive disorders are rarely encountered in medical practice excepting among the poorest and most ignorant families. They play a relatively minor role even among hospitalized patients. In infant wards they have largely given way to patients with infections of the respiratory tract. The high peak of occupancy has shifted to the cold months and the low period to the warmer months.

Striking changes have occurred during the past twenty years. Then, serious disorders were very common and the infant mortality rate was still high. A heavy toll of infant life was exacted each summer and early autumn by what was improperly called "summer complaint"—a dysenteric diarrhea rarely seen today. The hazard of the second summer was a tradition handed down from generation to generation as a period of unique danger because the infant was then as a rule no longer on the breast. This risk does not exist today. The change has largely come about by our great advance in the knowledge of the science and art of infant feeding. The infant welfare programs have been of great importance. Through the far-reaching effect of the propaganda directed toward keeping the well baby well, the general public has been educated to accept modern methods of infant hygiene.

Common disorders of infancy will be considered in the order of their earliest appearance.

INANITION FEVER

Inanition fever sometimes occurs two to three days after birth and is due to the fact that the infant does not absorb enough fluid. The dehydration may be the result of insufficient fluid or nourishment being offered to the infant. It is most commonly seen in breast-fed babies. Since the mother's milk does not make its appearance until the third day, the only fluid the baby receives is colostrum, the supply of which may be scanty. The treatment consists of offering 5% lactose water frequently to the infant. If the dehydration is extreme, with the temperature going as high as 105°, a small interstitial, 10 cc. per pound of body weight of 5% glucose in normal saline, may be given and repeated if necessary. Prophylaxis is, however, very important. Any newborn infant running a fever should be reported at once and additional fluid offered.

Dr. McGarry is associated with The McGarry Clinic in Niagara Falls, Ontario.

CONJUNCTIVITIS

A purulent discharge is very frequently encountered in one or both eyes of the newborn infant during the first or second day. This condition is nearly always due to an irritation from the silver nitrate instilled in the eyes at birth. The silver salts cause an inflammation of the conjunctiva with a purulent discharge. It should never be confused with gonorrheal ophthalmia as the signs of this condition do not appear before the fourth or fifth day. The treatment of this simple conjunctivitis is boracic irrigation three times daily. The condition usually lasts for two or three days.

VOMITING

Vomiting is one of the earliest and commonest complaints encountered in infancy. It may consist only of a regurgitation or spitting up of small quantities at a time, or it may be more definite vomiting which may completely empty the stomach and be explosive or projectile in type. The latter is always indicative of indigestion or dyspepsia, if it is prolonged, and especially so if it continues up to the time of the next feeding. If the food merely rolls out of the mouth

for a time after feeding, it usually means nothing more than that the baby has taken a larger amount than his stomach can contain. Such vomiting is not pathological. Much of this regurgitation may be avoided if the baby is supported in a nearly erect position and gentle pressure made on the stomach. He may be held up over the mother's shoulder and patted on the back, commonly known as "bubbling." Many babies require such relief after every feeding and not infrequently during a feeding.

Indigestion as a cause of vomiting may be due to too much food (overfeeding), too frequent feeding, or to an improper mixture of the food elements in excess of the infant's tolerance. Carbohydrate is rarely the cause of vomiting. The fat, however, is a great offender due to the fact that it delays the emptying of the stomach. Some infants have definite intolerance to it. The natural therapeutic resource is the reduction of fat by the use of less milk or by using skimmed milk.

Vomiting occurs in nearly all febrile diseases. It is generally most marked at the beginning of the illness. The infant must never be forced to eat while the fever persists. It is often necessary to eliminate milk and substitute a sugar solution until the temperature is normal.

Vomiting is merely a symptom that demands explanation and relief, if possible. It is unwise to take it too seriously because there are infants in whom it is best to accept some vomiting as an unpleasant but not very harmful condition.

Diarrhea

Diarrhea in an infant is an outstanding sign or danger signal that something is wrong and calls for immediate treatment. By diarrhea, we mean an increased frequency and looseness of the stools, beyond the normal for that particular infant and considering the food he is taking. The normal number of stools and degree of looseness depends upon the infant's diet. Bottle-fed infants normally have one to two stools per day, semi-formed to formed. Breast-fed infants may have four to five a day—loose, yellow, curdy. Diarrhea stools contain small soft, friable, greenish, fat curds and mucus. Blood and pus do not appear in the minor forms. This type of stool is nearly always due to an intercurrent infection which results in a fermentative type of diarrhea. It rarely occurs in breast-fed infants. Treatment consists in cutting down the amount of carbohydrate in the feeding and increasing the amount of fluid to make up for that lost in the frequent stools. The feeding or milk may be boiled for a longer period with good result.

Constipation

Constipation never occurs in the breast-fed infant if it receives an adequate supply of breast milk. False constipation does occur, when the infant may go two or three days without a bowel movement and then pass one which is normal in amount and consistency. This happens because the infant utilizes most of the milk and leaves very little residue or bulk to stimulate evacuation of the bowels. *Under no circumstances advise a laxative* but rather reassure the mother that there is no harm in the infant not having a bowel movement. Concentrate on obtaining more breast milk.

Constipation in the artificially fed baby is most common and sometimes very stubborn. The infant passes, with difficulty, ball-like stools frequently streaked with blood. The fault is usually dietetic in origin, although it may be due to any factor that delays emptying of the bowels, such as, faulty habits, intestinal inertia, weak abdominal muscles, etc. The dietetic fault lies almost wholly in the use of too much milk. Boiled sweet milk with too little carbohydrate is a common fault. The treatment naturally follows both the cause of the constipation and the nature of the stool. After all the possible extraneous factors have been excluded the primary concern lies in dietetic control. The child as a whole must be kept in mind so that he will not suffer nutritionally from an unwise regulation of the diet. The underlying dietetic principle is a reduction in the amount of milk and

an increase in the amount of carbohydrate. Corn syrup and lactose are the most laxative sugars. It is well to add starch to the diet in the second or third month of infancy and vegetables and fruit, especially prunes and prune juice, in the fourth and fifth month respectively. Orange juice, contrary to popular belief, is not laxative and is of no use in the treatment of constipation. Acid milks and evaporated milk are much less likely to produce constipation.

If dietetic measures fail, then laxatives and suppositories must be considered. The employment of these measures, if used with understanding as to their indications and effects, does not warrant any serious objection. Suppositories are indicated if the stool is of easily-passable consistency. Laxatives are indicated if the stool is unduly hard or impossible to pass. Enemas should not be used excepting when one thorough evacuation is desired. The simplest laxative is mineral oil. It is best given in two doses daily of one to two teaspoons each. In severe cases of constipation a small dose of milk of magnesia may be used along with the mineral oil, the dosage being one half to two teaspoons in the infant's evening bottle of formula.

Experimental evidence has indicated that vitamin A is insoluble in mineral oil and may be imperfectly absorbed when the latter is used. Clinical evidence of a resulting deficiency is wanting. If the constipation is false or of the soft, easily-passed stool variety, rectal or anal stimulation is all that is necessary. This may be accomplished by merely pressing on the anus or through the introduction of a foreign body which stretches the sphincter—e.g., the nozzle from an infant syringe or by the use of glycerin suppositories and soap sticks.

Of the greatest importance in prophylaxis and treatment of constipation at any age is the early training that brings about the emptying of the bowels at regular intervals. This can be accomplished readily by instructing the mother to place her infant, as early as two months of age, on a chamber after the morning feeding and to insert a suppository or soap stick. After a few times most infants will develop a reflex that produces a bowel movement without added stimulation.

Thrush or Sprue

This is a condition occurring as the result of a mould growing in the infant's mouth and producing a white membrane or patches on the tongue and the insides of the cheeks which cannot be rubbed off. It is very infectious in nurseries and is the result of the use of unsterile nipples on the nursing bottles or "comforts." The treatment is the daily application of a 1% aqueous solution of gentian violet to the affected parts. Prophylactic measures are important and consist of the daily sterilization of the nipples and placing them in a saturated solution of borax. The use of "comforts" is absolutely condemned as a dirty and primitive practice. The sale of these might well be prohibited in all stores.

Skin Rashes

The minor skin rashes in infancy consist chiefly of prickly heat or some form of dermatitis due to irritation from: (a) saliva around the mouth, chin, and neck; (b) wool or dyed garments, or diapers; (c) baby oils.

The treatment of these rashes is quite simple and consists mainly in removing the irritating factor. Prickly heat is best controlled by advising the mother to put fewer clothes on the infant especially in hot weather, keeping him well powdered and by applying calamine lotion to the rash. Saliva may be excluded from the skin in the face area by applying a light layer of vaseline. Woollen or dyed garments may produce an eczematous condition and can be easily diagnosed by the distribution to areas where the garments are in contact with the skin. This type of dermatitis is frequently seen in the fall when the mothers first put the infants into new, colored snow-suits. The treatment consists in removing the irritating clothing.

Diapers are a very frequent cause of sore or excoriated buttocks with the

dermatitis extending up over the back, on the abdomen, and down the legs as far as the knees. This is due to the reaction of the urine to slight traces of soap in the diapers. If the buttocks are very sore it is advisable to leave the diaper off until the condition is improved. Instruct the mother to wash the diapers with a mild soap and rinse them thoroughly in at least three waters. Modern detergents do not leave any irritating film when used for washing. Boiling the diapers occasionally will eliminate all traces of ammonia.

The frequent application of a mild astringent ointment, such as zinc oxide, to the buttocks is recommended. Baby oils are mainly composed of a light mineral oil containing a mild antiseptic. Many infants are allergic to this antiseptic and a dermatitis results. This is usually characterized by a generalized redness of the skin over the whole body. The rash will disappear quickly when the use of the oil is discontinued.

Colic

This is one of the most common complaints today. The mother states that her baby is very cross, cries a good deal, and will not sleep. The baby "spits up frequently" and may have loose green stools. This condition occurs most commonly in hypertonic infants. These babies are born with a very excitable nervous system. They cry and fuss almost constantly, being upset very easily. The treatment is small doses of atropine and luminal and an environment which is quiet. Other causes of colic are overfeeding and underfeeding and may be found in both breast-fed or bottle-fed babies. Simple dietetic adjustment is usually all that is required. A simple enema of soap and water or a glycerine enema will relieve the infant temporarily until dietetic measures have had time to take effect. Contrary to old beliefs, no baby need suffer with colic.

Teething

Teething is a normal physiological process and in the large majority of infants causes no problems. If the infant has any symptoms of upset, the teeth should be blamed last. The old axiom that teething causes convulsions should be completely forgotten. At six months, the usual age for the teeth to start erupting, the infant may have a mild digestive upset with slight fever lasting for a day or two, and may be slightly irritable and refuse parts of his formula but he is never acutely ill. Small doses of aspirin will relieve him during this period.

Upper Respiratory Infections

These infections are most commonly seen during the winter months and are characterized by a slight nasal discharge, fever, and anorexia. They include nasopharyngitis, tonsillitis, laryngitis, and bronchitis. In the simple, uncomplicated case the infection lasts from ten days to two weeks. The treatment is mainly symptomatic. Ephedrine nose-drops may be ordered to relieve nasal congestion, small doses of aspirin to reduce fever. Other measures include some cough sedative, increased fluids, proper elimination, and the avoidance of chilling. The sulfa drugs and penicillin are not recommended for the routine treatment of these infections, as little or no effect will be achieved if the infection is due to a virus. The antibiotics should be reserved for the treatment of complications, such as otitis media, cervical adenitis, or infections which do not respond quickly to symptomatic treatment.

A Complete Rest

Every worker needs a complete holiday rest at least once a year. Everyone needs a break from routine, a change in the pace of living. Executives who fail to take vacations because of pressure of work, or craftsmen who prefer the bigger pay cheque to an annual holiday are doing themselves a disservice. The body needs time to recuperate now and then. Give yourself a chance to be healthy.

Preventing Infancy Ailments

ELSIE SCHUMAN

Average reading time — 7 min. 36 sec.

MORE AND MORE it is realized that most of the ailments of infancy and childhood, both major and minor, can be prevented if forethought is used. Preventive measures are much less expensive from the standpoint of both the community's and family's pocket-book, to say nothing of the needless anxiety saved the parents.

The public is increasingly receptive to the importance of teaching the young mother and, more recently, the father to prepare for the coming of their newborn infant. There is a growing realization among parents that there *is* something to be learned. They rarely think now that "instinct" will tell them the right course of action. This new viewpoint has been brought about through various educational efforts and channels. The care that the young men received in the armed forces has taught them the wisdom of preventive medicine and good medical care. The schools are continuously improving their teaching to the children so that health ideals are woven into all their activities. Thus, when parenthood is reached, they have a much better understanding of the health needs of their family.

Such agencies as the Health League and other community endeavors contribute a great deal to the public's education. But most important is the role played by the departments of health—national, provincial, and local—and by all the public health agencies related to the departments. The literature, both preventive and that dealing with active health problems, put out by the departments is excellent. It can and should be made available to the families. The connecting link between the source of information and the families is, of course, the nurse, who must interpret health in its broader aspects and also in those particular problems which confront the individual family. It is her job to direct these families to sources of help available to them.

On her rounds, the public health nurse realizes that so many of the minor ailments of infancy could have been prevented if the parents had been taught sound and practical ideas on the care of their child. It is well to remember though, that in teaching the parents, they must not be robbed of their initiative. The teacher will not be at hand in every minor emergency but must teach the family to think out a situation, making the proper use of the excellent literature on infant care at their disposal, such as "The Canadian Mother and Child."

The nurse realizes that the best time to prepare the family's thinking, regarding the care, feeding, and healthful surroundings of their new infant, is before the arrival of that individual. Chaos is often encountered when visiting a home where the new parents are suddenly brought face to face with such problems as the handling of the infant, its feeding, rest, etc. Many an infant has been badly upset by over-handling and nervous tension on the part of the parent with the resultant feeling of insecurity. Reaction is shown in digestive problems which cause an endless chain of changes in feedings, upsets and further upsets, leaving an utterly exhausted mother and a badly upset infant. This is a situation which takes a great deal of effort to set right.

The nurse can do much to give the parents the beforehand appreciation of the value to both the mother and infant of breast feeding. Teaching the mother before and after the birth of the infant how to develop the supply of milk by rest, relaxation, balanced diet and sufficient fluids, by the proper stimulation of the breast to produce the milk, by the regular nursing of the

Miss Schuman is nurse-in-charge of the Niagara Falls branch of the Victorian Order of Nurses.

infant and the emptying of the breast after the feeding. It is always wise for the nurse to take the temperature of the newborn infant during the first few days. An elevated temperature should be reported, as it might indicate the insufficient absorption of fluids from a scanty supply of breast milk. This is usually counteracted by giving 5% glucose solution which tides the infant over until a sufficient supply of breast milk is established.

When she first comes home from the hospital it is wise to warn the mother that, until her body becomes adjusted to the added exertion, there may be a decrease in the supply of breast milk. This decrease is, as a rule, of no serious consequence to the infant as the milk supply is usually quickly re-established providing the mother observes the rules of diet, rest, relaxation, and proper methods of breast feeding.

The young mother, breast feeding her first infant, is often alarmed by the lack of stool which she terms "constipation." It should be pointed out to her that the infant is using all the milk for body needs and little residue is left.

Among the common problems encountered by the nurse on her rounds is constipation in the bottle-fed infant. The stool is often stone-hard with streaks of blood on the outside, causing pain on passage and constant irritation of the rectum. It is well for the nurse to check with the mother the method she uses in making the formula, as frequently she boils it too long. Boiling has a tendency to constipate the infant, as also does the loss in water content of the formula, the water being evaporated by excess boiling. Occasionally the mother does not use a standard tablespoon to measure the sweetening agent and the infant receives less than he requires. This causes hardness of the stool. The mother should be encouraged to give the infant supplementary clear boiled water feedings between the formula feedings. If constipation still persists, the doctor should be consulted for adjustments in the formula or the use of laxatives.

If a case of diarrhea presents itself the nurse should check with the mother the procedures used in formula preparation. To the average housewife, sterilizing means pouring boiling water over the utensils which would most certainly not kill harmful organisms. The formula should be kept in an ice-box or refrigerator. If neither is available the department of health will supply printed directions for making a home-cooler. By far the safest method of teaching formula-making is to actually demonstrate it to the mother, and have her give a return demonstration.

The nurse visiting in the home will soon notice any obvious uncleanliness or lack of sanitation. She should point out to the family the possible ways that infection might be spread in their home. She should then have them plan with her how to remedy these conditions. The exclusion of flies from the home is one important item of sanitation.

The boiling of freshly laundered diapers is often advisable in cases of diarrhea. Infants who have more than four or five stools a day should be reported to the doctor who might wish to make some change in the formula.

In cases of infantile vomiting, the family should be taught the difference between regurgitation and dangerous vomiting. It is quite normal for the infant to bring back a teaspoonful or two of its feeding. This usually indicates that he has had a little too much and is wisely disposing of it. But when the vomiting is of a projectile nature or when the whole formula is continually brought up immediate medical attention is required as the body fluids may be quickly depleted, placing the infant in a serious condition. Occasionally over-handling during or after feeding causes vomiting and this should be checked.

Thrush, small white patches which occasionally develop in an infant's mouth, can be distinguished readily from milk curds. Thrush is frequently associated with uncleanliness and lack of care in formula preparation. The bottles should be well soaped before boiling them for ten minutes. They

must be completely covered with the boiling water. The nipples should be placed in a clean muslin cloth and boiled. Placing them in a muslin cloth brings the nipples below the waterline instead of merely floating on the surface. It is wise to teach the mother never to wash out the infant's mouth unless the doctor so orders.

In cases of upper respiratory infections, much can be done in the way of prevention. Anyone with colds should be excluded from the vicinity of the infant. If the mother is infected she should be taught to wear a mask when handling the infant. The mask should be changed frequently for a freshly laundered one—a large handkerchief doubled may be used. When the infant develops a cold, fluids should be forced and the infant should be handled as little as possible. It is often advisable to elevate the baby's head on a pillow to ease its breathing. The nursery should be kept well aired but care should be taken to avoid chilling.

Careful teaching will result in a good understanding on the part of the parents of the proper care of the newborn infant. They will know that good habits of healthful living can do much to prevent the common minor disorders in infancy.

Colostomy in a Child

GWENNYTH BARTON

Average reading time — 6 min. 24 sec.

ON FEBRUARY 10, 1948, Bruce, aged nine, was admitted to hospital with a history of a blood tumor on his right thigh, and bleeding per rectum since birth, with a resulting anemia through loss of blood. After walking him to the ward, it was noticed how pale the child was. His face was dead white, including his lips. On his right thigh was a large birth-mark, presenting a rather mottled appearance. The veins on this leg, and especially the foot, were very enlarged and appeared varicose. His temperature was normal.

On admission, the routine tests were done. Urinalysis and Kahn were negative. Bruce's hemoglobin was 20 per cent, his white cell count was 10,200, and his red blood count was only 2,600,000. A specimen of stool was sent to the laboratory and returned negative for occult blood. Blood was taken for grouping and cross-matching.

That night, in view of the child's low hemoglobin, he was placed on hematotherapy, receiving within the next few days six blood transfusions of approximately 500 cc. each. His hemoglobin rose from 20 to 69 per cent. Two days after this therapy started, Bruce's eyelids became edematous

GWENNYTH BARTON

Miss Barton graduated last September from the Children's Hospital, Halifax.

and the veins in his left foot became more swollen and enlarged. On the last day of this therapy, he had a severe reaction from the blood transfusion. He became very uneasy and complained of thirst. Two hours later he had a severe chill and his temperature rose to 104.2° by midnight. With discontinuation of the blood transfusions, alcohol rubs, fluids, and other nursing measures, his temperature was down to 98° at 4:00 a.m.

Bowel elimination was not regular, so he was given magnolax, drams 2 b.i.d. for three days, with good effect. Two days later Bruce went to the operating-room for a sigmoidoscopic examination. He was very apprehensive about any mention of the O. R., so everything was done to allay his fears and prevent him from becoming upset.

Two days later Bruce was taken again to the O. R. in the hope that the hemangioma might be removed from the rectum but there was too much bleeding to attempt any surgery. On February 24, Bruce was placed on chemotherapy for two days, receiving sulfadiazine gr. 7½ q.4.h.

On the night of February 25, a soap-suds enema was given. A large amount of fecal material was passed and the return flow was colored with blood. Seconal gr. 1½ was given at h.s. and on the morning of the 26th Bruce was prepared for operation. A surgical preparation was done to abdomen and anus. An intravenous of 5% glucose saline was started in the dressing room and sodium pentothal intravenously was also given. Bruce went to the O. R. at 8:00 a.m. for an abdominal-perineal resection of an hemangiomatous section of bowel, which left him with a permanent colostomy, the anal opening being closed. He returned from the O. R. at 10:30 a.m. in apparently good condition. A blood transfusion had been started in the O. R., and was still running on his return. A catheter was inserted in the child's urethra and on return a drainage bottle was attached to the bed. Morphine gr. 1/12 was given q.4.h. p.r.n. for pain. Bruce was placed on intravenous therapy, receiving approximately 1000 cc. of fluid per day. Oral fluids were taken well and tolerated.

The next day, penicillin, 20,000 units intramuscularly q.3.h., was started. Post-operatively Bruce had a mild retention of urine. His bladder was irrigated frequently and pressure applied over the bladder area. Only small amounts of urine were expressed at a time. The catheter was removed two days later and catheterization was necessary twice afterwards. There was a moderate amount of mucoid discharge from the colostomy, and a vaseline dressing was applied to the opening. At first jelonet was used, but this proved too expensive so vaseline gauze was substituted. A purulent discharge came from the region of the anus and a dry dressing was applied.

On March 1, six days after his operation, a soft diet was started and taken well. The next day the penicillin was discontinued.

On March 3, Bruce complained of abdominal pain, which was diagnosed as bladder spasm. Codeine gr. ¼ s.c. was given p.r.n. for this. At 7:30 that night the child had a convulsion, starting with his face and hands, spreading to include his entire body, increasing in severity and lasting about two hours. Phenobarbital gr. 1½ intravenously and calcium gluconate 10 cc. intravenously were given. Oxygen and suction were used p.r.n. and an intravenous of 10% glucose in distilled water was started. A lumbar puncture was done and the fluid returned clear and under slight pressure. The drain was removed from the anus at this time.

The next day the child was very pale and listless and had no recollection of the convulsion. Phenobarbital, gr. ½ q.4.h. p.r.n. orally, was given for its quietening effect.

On March 5, all but two of the abdominal sutures were removed. The child was voiding satisfactorily and the intravenous therapy was discontinued.

Three days later the area around the remaining sutures appeared very swollen and inflamed. Stools were loose and frequent. Two days later

Bruce was put on a special constipating diet. Colostomy irrigations were started and given every two days. His general condition seemed to be improving.

On March 15, Bruce returned to the O. R. for a colostomy trimming. No anesthetic was given. The next day it was noticed that there was still a purulent discharge coming from the anus. Apparently a sinus had formed. Perineal irrigations of sterile water were ordered three times a day. The solution returned clear and this was discontinued three days later and an alcohol dressing applied.

Bruce's special diet did not have the desired effect, so Tincture of Camphor Co., minims 10, was given three times a day for four days. The child was now quite bright and active about his bed.

On March 20, tub baths were started. Bruce was eating well and bowel movements were controlled to three well-formed stools a day.

On March 31, the child was up walking around and four days later he was discharged, with a hemoglobin of 77%, eyes bright, and cheeks tinged with red. Instructions were given his mother regarding his diet and colostomy irrigations.

The prognosis in this case is very good. With proper care of his colostomy and attention to his diet, Bruce may grow up to live a fairly normal life.

In the Good Old Days

(*The Canadian Nurse, July, 1909*)

"The International Council of Trained Nurses offers its sincere and respectful congratulations to the women, and especially to the trained nurses in those Countries and States in which they have been granted the rights of citizenship.

"This Council is convinced that the possession of the Parliamentary Franchise, which places in the hands of women power and responsibility, will raise the standard of women's work and, in consequence, increase the professional efficiency of Trained Nurses."

We wonder how many nurses today make use of their right to vote—a privilege that relatively few women possessed forty years ago?

* * *

"June 1, 1905, saw the inauguration of the Central Registry of Graduate Nurses of Toronto. Miss Land, a graduate of the pioneer training school of Canada, was its first member. Since that time, the Central Registry has steadily grown in numbers, in usefulness, and in influence."

* * *

"The old French monks employed and perfected a system of hand rubbing for certain ailments, which later was elaborated and exaggerated into a more modern 'osteopathy,' and applied to every known ailment, with assurance of cure. Revolt against this misapplied use of an excellent therapeutic agent has given us still more modern 'massage' for selected affections."

* * *

"Formic acid has been used in 412 cases of diptheria with the result of diminishing the death rate by 1.8 per cent. This is given as a heart tonic replacing strychnine."

* * *

"Prepare catgut (for surgery) by immersing the strands in a watery solution of 1 per cent iodine and 1 per cent potassium iodide crystals for eight days, then transferring to a dry sterile jar covered with gauze. This catgut is antiseptic and aseptic; it absolutely cannot be infected."

* * *

"It is probably the exception rather than the rule that a baby passes through its first two summers without at least one sharp attack of gastro-enteric disturbance."

Roasting meats at a low temperature avoids shrinkage and the loss of soluble proteins and the B vitamins in the drippings. A roast that is cooked slowly from the beginning will provide extra servings, the meat will be more juicy and tender, and the food value higher.

You and Yours

C. E. McRae, M.D.

Average reading time — 8 min. 48 sec.

I INTEND TO touch briefly on some of the high points of heredity or genetics as it bears on the human race of today and of the future. To begin with, let us consider some of the early principles of reproduction.

The individual starts out as one cell composed of protoplasm and nucleus. The latter contains particles called chromosomes. The number of chromosomes varies in different species. The human cell contains forty-eight chromosomes, the insect cell contains only eight. Not only the original cell but any cell in the human body contains forty-eight chromosomes.

The original cell that goes to form the individual is started by the union of a male and female cell, or sperm and ovum. Each sperm and ovum contains twenty-four chromosomes. When the sperm and ovum unite the chromosomes line up together in pairs to give us the cell containing forty-eight chromosomes.

It has been noted that the chromosomes have different forms. The chromosomes in each original cell pair off together. Contained in these chromosomes are strings of smaller particles called genes. These chromosomes, or the genes contained in them, are the factors that determine what the characteristics of the new individual will be.

Possibly the earliest characteristic that attracted people's attention was whether a baby was male or female. This factor is determined by a chromosome in the sperm. Of the twenty-four chromosomes in each germ cell, X and Y are the sex chromosomes. In any given sperm there will be either an X sex chromosome or a Y sex chromosome, never both. In the ovum only the X sex chromosome occurs. Thus, if a sperm with an X sex-factor unites with an ovum, a cell with forty-six regular chromosomes plus two X chromosomes will result. This produces a female individual. If a sperm with a Y sex-factor enters an ovum, a cell with forty-six chromosomes plus one X chromosome and one Y chromosome will result. This produces a male individual.

To go farther it is recognized that in the forty-eight chromosomes are contained all the factors that determine what characteristics the individual will have. Color of hair, color of eyes, skin texture, length of fingers, height, emotional variations, heart tendencies, and a million other characteristics that go to make up an individual are there.

Now these factors are contained not only in the final individual cell but in the chromosomes in both the sperm and ovum—that is, the sperm contains a factor to determine color of hair, the ovum also contains a factor to determine the color of hair. Let us say the sperm contains a factor for black hair, the ovum contains a factor for light hair. What will be the result? We may get an individual with black hair, medium hair, or light hair. Some factors may be more forceful than others so we distinguish between dominant and recessive factors. How these combine is the determining factor of the resulting color of hair. Whatever characteristics an individual will have is absolutely determined at the time of the matching of the chromosomes in the two germ cells. Once two germ cells unite that new individual's characteristics are established.

The transmission of characteristics was first studied in 1857 by Mendel, an Austrian monk. His study was confined to the flowers of his garden and finally the evidence pointed to what we now know as the "Mendelian Law." It was not until twenty-three years later that the importance of his work was recognized, when Morgan revived the study and applied the

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Mendelian Law in his experiments with the fruit fly.

These studies would take a long time if we were to go into them in detail. However let us consider briefly an interesting example in man. If a negro marries a white, all children will be mulatto. If two mulatos marry there may be black, dark, mulatto, light or white children. If a mulatto marries a black, their children may be any color, but never white. If a mulatto marries a white, their children may be any color but never black. There is a general idea that if a white girl marries a mulatto she is liable to have a black child. Recent studies have proven this to be erroneous.

Let us return to the germ cell. As we have noted, the sperm combines with the ovum to form a cell with forty-eight chromosomes. This cell begins to divide and multiply. Division may take place in two ways:

1. The chromosomes may split to form ninety-six particles and the cell divide, yielding two cells with forty-eight chromosomes.

2. The chromosomes may separate themselves into two groups of twenty-four chromosomes and the cell divide to give two cells each with twenty-four chromosomes.

The first process of division is the one that yields the new individual. The second process of division gives us a continuation of the male or female germ cell. In these cells are the chromosomes that will determine the characteristics of the children born to those individuals. From this it can be seen that the characteristics that anyone will transmit to his children are determined before he himself is born. We also see that each germ cell is a part of the original germ cell, hundreds of generations back. We might say that our sole purpose is to be the carrier of the germ cell, to protect it until it has the opportunity to start another individual, who in turn will carry it for a short time. For example, the important part of wheat is the kernel. The straw and chaff are merely a nourishing and protecting implement. Thus the body of the individual is merely the straw and chaff—the germ cell is the kernel.

Darwin began his work with the theory that environment acting on the individual affected the germ cell to the extent of changing the characteristics of that individual's offspring. With our present knowledge we realize that environment will affect an individual, but it does not change his germ cells. That is, the chromosomes in the germ cell of an individual before and at birth remain the same throughout life. A man or woman may attain great success in some line of work—science, music, etc.—yet the chromosomes transmitted to any child of his will be the same whether it be conceived early in his life or after he has reached the peak of his success. In the same way, a beautiful woman with her face badly disfigured by an accident will have as much opportunity of having beautiful children as if the accident had never occurred.

How then is it possible for changes to take place? This may happen in two ways.

Modification in mating: If a mulatto mates with a white, the children will be of various colors but not true black. If these in turn are mated with whites, the dark strain will gradually be minimized. We have this demonstrated in domestic animals. Some cattle have been developed for dairy purposes, some for beef. A herd of wild ponies, if allowed to mate indiscriminately for one hundred years, would still produce wild ponies. However, if one set about selective mating one could produce any type of horse wanted.

Why is it that in northern Europe we have a hardy, sturdy race of people like those in Sweden? Is it not possible that the first people who went there were a hardy, aggressive people? Could it be that those of their children who were not so hardy died off and did not reproduce?

Mutation: This is some change in the chromosomes that happens accidentally. Just as a plant may have a defective leaf, so a chromosome may carry some defect. A family whose ancestry is absolutely sound on both sides for several generations back may produce a child with some deformity, due to a defect in a chromosome. This is seen quite frequently in animals. However, if this deformed individual is allowed to reproduce, there is a tendency for that mutation to be transmitted and to become established in future generation.

Institutional Nursing

The Community Looks at the Hospital

HECTOR BERTRAND

Average reading time — 14 min. 12 sec.

THE COMMUNITY comprises two main classes of people—the professional and the non-professional. The professional class may be divided into two categories—the successful and the non-successful. Again, you may divide the non-professional class into three categories—the rich, the middle class, and the poor. To whichever class they may belong, all of these people have their opinion of the hospital and, whether it is good or bad, they will sooner or later pass it on to the public. So let us share in their conversation and put ourselves in their place in order to find out what they know, or think they know, about our hospitals. Any opinions they may have, come either from being a patient or a visitor, or from simple hearsay.

THE PATIENT

The successful professional man, when sick, may come into our hospitals for treatment or for an operation. He may not be rich, but he has the very best of education and expects the same of all those with whom he will come into contact during his sojourn in our institutions. Himself from a respected family, he has been trained at home, from his earliest childhood, in good manners and courtesy, and has been given the finest of education. He will expect to find a a second home while in our midst. The most minute details of life are brought to light through his keen sense of observation. He will notice, more than a person of any other class, the courtesy of a doctor or of a nurse in knocking at his door before entering and in greeting him on their arrival. The least little noise will disturb him, sometimes to the extent of spoiling his rest. He will notice any deficiency with regard to education on the part of our personnel. He may not say so nor pass any remarks though, if he does, as a gentleman, he will do it with the utmost courtesy. Nevertheless, the educational standard of our hospitals will impress him immensely and more, to a certain extent, than the material comfort or even the professional qualifications found there. If our hospital does not meet, in his own opinion at least, this educational standard, he may go back home thoroughly satisfied with the medical care offered to him but, at the same time, with a certain dissatisfaction over this lack of education which he expected to find and, in fact, to which he is entitled in a professional institution. On the other hand, if he has discovered a second home during his sickness, his recommendation to his friends will be the best propaganda in favor of our hospitals.

The non-successful professional man is a very different type of patient for, having lost all influence in the outside world and having too often in life missed the chance to live up to his previous education, he is exacting and will not easily forgive the least little infraction because he will feel that once more he is being deprived of something to which he is inherently entitled. He will be far more demanding than the successful professional man and will, for that reason, be a hard patient to handle. Theoretically, he is rich—that is, educationally speaking. In reality, however, he is a sort of degenerate and will not miss

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an opportunity of imposing his various whims upon others. He is a very hard man to satisfy and, if he leaves the hospital discontented, we may lose many a prospective friend among the people with whom he later comes in contact. On the other hand, although his demands may be excessive, if we can cope at least to a certain degree with his desires, we have won a friend and perhaps many more.

The rich non-professional man knows that with money you can buy just about everything. The first thing he will do when he comes into his room will be to try to tip the nurse in order to get better care. He may not ask the same educational standard as would the man of the professional class, but he will demand the utmost material comfort. In accordance with his training at home he has to have the best of food, the best of chesterfields, and the best of service. Coming into a hospital he expects, probably more than any other class, specifically, more than the professional man, to find these things. He sometimes lacks education and, if so, will easily overlook any educational deficiencies. Due to his social status, he may be inclined to order people about but, nevertheless, he is, as a rule, a fairly easy patient to handle and, if we provide him with sufficient material comfort, he will be thoroughly satisfied. We have gained one more friend in the community.

The middle-class man is our problem. He is more to be pitied than blamed. Very often unforeseen circumstances and conditions of life, over which he has no control, have put him in this class of people who deserve our particular attention, at least in the hospital field. Under his rich garments lies a certain poverty. He has to be well dressed and must provide a certain amount of entertainment, due to his social position. This he does by denying himself certain necessities of life. When he comes into the hospital he expects, because his friends will expect it of him, to be considered a well-off man. His trials and tribulations begin in the admitting office when he starts discussing the prices of rooms, for he must have an expensive room, quite often special nurses, all of which he cannot afford and, during his stay in the hospital, he always keeps in mind that he may never be able to pay for all this comfort which he has ordered on his arrival.

Incidentally, one or two blood transfusions may be necessary. If the man were rich there would be no question whatsoever. Even if he were poor our problem would be solved, for public charity would look after him but, unfortunately, he is of the middle class.The administration wants to know whether or not he can pay for it, and the patient himself is worried. Exteriorly he belongs to the well-off class, but in reality he is a poor man and his position is more difficult because he is a sort of misfit. If he leaves the hospital dissatisfied, the repercussions of his discontent will be immeasurable. He belongs to that class of society whose members are the most numerous and often the most critical. His influence will be far-reaching if we have not provided him with at least most of what he expected. Through him we have given uncomplimentary propaganda to our institution. If, on the other hand, he leaves, if not completely satisfied at least not dissatisfied, he will not miss an opportunity to put in a word in our favor, mentioning how good the beds were, how excellent the service and, above all, how kind and courteous the nurses and personnel were to him, using him as he deserved to be used in conformity with his social status. Through this patient we have won probably a hundred, if not hundreds of friends.

The poor man will, as a rule, be satisfied with a little less material comfort, but he is entitled to the best medical care. He knows he is poor and, when he sees the inside of some of these wonderful institutions called hospitals, a tinge of jealousy may invade his soul, especially if he is in a place where he can discern a greater degree of comfort given to richer people in the same institution. I personally think it is serious mistake, in a

hospital, to put public wards across the corridor from private rooms and even suites of outstanding luxury. The poor man cannot help noticing such comfort and, willingly or not, he will observe that nurses and all personnel, as a rule, will visit the rich man's room very often while he himself is restricted to a minimum of visits. As a human being he has perhaps a kinder heart than the rich man. He is entitled to the same affection, but in effect he may be deprived of most of this because he has not the means to pay for a private room or for a suite.

Irrespective of what exigencies the rich or the poor, the professional or the non-professional man may have, there are three needs which are common to all classes of society.

We must provide our patients, all our patients, first, with the best possible professional care. The poor, as well as the rich, are entitled to qualified surgeons and physicians. The non-professional man, as well as the professional, should have qualified nurses to look after him. Our hospitals should have a well-trained staff to look after our patients young or old. Our professional care for every patient should be of the first quality and this includes the food, the beds—everything.

All our patients in hospital are entitled to good moral and religious supervision. I feel it is a duty for our hospitals to provide any patient with the minister of his faith, whether he be Catholic or non-Catholic, Christian or non-Christian. The latest discovery of psychiatry has been a shining example of the fact that, in many instances, you cannot cure the body if you do not look after the soul. I am certain that any Catholic would greatly appreciate seeing a priest and going to confession before a serious operation. The nurse preparing that patient for the operation should not display any sign of impatience to the sick person or to the incoming visitor because she has been, or at least thinks she may have been, partially hindered in her work by the coming to the bedside of this intruder. I also believe that, in a case of serious illness, a person of any faith whatsoever will benefit immensely from the visit of a minister of his own faith. If he does ask for that minister, I personally feel that the hospital should go to a lot of trouble to provide him with this consolation. Moreover, any hospital, regardless of its denomination or race, should welcome that man and show him the utmost courtesy just as if he were one of the staff. In fact, he may in an intangible yet appreciable way contribute immensely to the patient's recovery.

There must be, in our hospitals at least a minimum of supervision. I have often been told that this supervision is deficient. I mean this—we must often protect our patients against the visitors, sometimes against our own personnel and staff. I recall a case where a young woman asked me, after a sad experience, why we did not see that a reliable nurse accompanied doctors on their visits to the women's rooms, especially when we were dealing with young doctors and internes.

This is what all classes of people will expect when they come into one of our hospitals. Are they entitled to all this? That is another question but, whether they be or not, if they expect to find these things in our institutions they will be dissatisfied if they do not. If the public does not deserve all this it is up to us, through a good program of public relations, to educate the community with regard to our services. Needless to say, most of these patients are convinced, when they see these beautiful buildings, that the hospital is rich, that somebody is making a lot of money, that money is not always well spent, and that the whole thing is sometimes a racket. Let us tell them of our expenses and of our trouble in making both ends meet, and the patients will more fully appreciate what they receive, even though they receive less than they expect when they come in.

The Visitor

The visitor to the hospital is also a factor in moulding the opinion that people may have of our institutions. The visitors also are divided, as the

patients are, into different classes. We have, therefore, the professional class—thoroughly successful in the world. As a rule, they appreciate a well-trained and educated personnel, but quite often they are not nearly so exacting as are some other classes. They go their way. They have a friend to see and they do not bother with anything else.

The non-successful professional man is a very embarrassing visitor. He quite often expects the whole staff and personnel to be at his disposal when he comes in, as though they had nothing else to do. He is convinced that he has not received his rightful share in life, due to the fact that his professional career has been unfruitful. He often holds it against the whole of humanity and, suspicious of everybody, the least little inconsideration hurts him deeply. He will notice, with a certain resentment, that the nurses have not greeted him on the floors as he went by and, leaving the hospital, he will forget that the personnel, whose first duty is to look after the sick, are already over-burdened and are too busy to think of their lack of courtesy to his individual person. He feels he has not been treated in accordance with his rank.

The non-professional rich man can afford to pay for every service. He is quite often sensitive to honors and will notice with great satisfaction any sign of consideration shown to him. If he discovers in an institution a certain tinge of luxury plus a considerate staff, he will be our best public relations officer. Otherwise, he is liable to forget the good medical care given to his friends or relatives because, in his opinion, the most important thing is missing.

The middle-class man will be quite surprised if he finds out that he can go through the whole institution without being noticed. After all, he has a certain social standing and feels that people should be mindful of this.

But the poor man may have a very good reason to complain when he visits the hospital. He cannot see his friends or his relatives, as the rich do, because of a disciplinary reason which may be good. However, this same rule will remind him of his poverty. He will be turned back at the door because it is not the proper hour and, at the same time, he will see others going by to private rooms to pay a visit to their friends or their relatives. He may not be entitled to the same privileges but he cannot help resenting this. I do not think that there is anything that goes down deeper into a poor man's heart than a certain consideration given to him by persons of the rich or of the professional class. He will never forget a greeting from a doctor as he walks along the floor or a kind word from the head nurse or the nurse in charge of his friend or relative. Courtesy on the part of any of the hospital personnel will give him the impression that in this institution they treat the poor with as much consideration as the rich. When he looks at the hospital he will remember these small acts of friendliness and we have won a friend who may be poor, but one who is a sincere supporter of our ideals.

There is one point which I would like to emphasize. The visitors, be they rich or poor, are entitled to the same sympathy and treatment. I have not yet discovered any substantial justification for refusing, in certain instances, a cup of tea or coffee to the poor on the occasion of a visit to the hospital and distributing it generously to the well-off.

When, unfortunately, a death occurs that is the time when there must be no distinction of race or creed, poor or rich. When the rich man loses a relative, let us say a wife, we all understand that his life is broken and we do offer him sympathy. When the poor man loses his wife we should be even more understanding and realize that, not only is his home broken, but he may not have the financial means to provide a servant to look after his home and the youngsters. If the rich man deserves sympathy, the poor man deserves still more consideration because his trials have doubled in intensity.

When the poor man looks at the hospital, it is with the eyes of the poor

that he will judge us. If we have learned with our intelligence, still more with our hearts, to understand his sorrows and tribulations, we will have taught him, not only in word but in action also, to consider our charitable institutions as organizations of true charity. The community will then look at the hospital with understanding and appreciation.

Hearsay

The results of hearsay may be very harmful to any institution. Probably the greatest detraction against a hospital's good name is due to hearsay. It may have originated through a friend who was a former patient and who may have been well or poorly treated, or through a timely or an untimely visitor. Nevertheless, it has gone on its way causing considerable damage to the hospital.

The five classes of people mentioned above, plus all those who directly or indirectly come into contact with the hospital, constitute the community which will look at the hospital, either to criticize or to praise it. Perhaps it is an employee who feels he has been ill treated. He goes back to his family, tells his story of how rich the hospital is and what small salaries they are paying, how tough the administrator and the personnel director are and how they like to fire employees without even listening to their complaints or giving them at least a chance to justify their position. Within a short time the whole community knows of the incident. Perhaps it is a doctor who has had a disagreement with a nurse or an administrator. He tells his patient and the first thing we know it is not only the one person in the hospital who has a bad character, but the whole institution is simply unbearable. Or it may be a nurse who feels she did not get quite the breaks she deserved and, hence, she complains about the administrator or the head nurse, and finally everything in the office is wrong. It might even be a salesman who comes in at a very inopportune hour and, because the business manager or the administrator does not put himself at his disposal for a considerable length of time, he has more to say against the whole hospital than if he had been ill-treated as a member of the staff or as a patient.

Finally, it could be a patient who was turned down at the admitting office. The admitting officer, under a nervous strain, may have said in a rather abrupt way that there was no place for him, or that he did not belong to the section of the country in which the hospital was located and, hence, should go back home and be treated in his own district. Admitting officers should always be mindful of the fact that even when they turn away patients they should do it with the utmost kindliness, taking the time to explain to the newcomer the circumstances and the reasons why he cannot be admitted. They should always keep in mind, especially when they do not know the person that, without suspecting it, they may be speaking to a very distinguished person. In all cases admitting officers should practise the greatest of courtesy.

Conclusion

To sum up, the community will appreciate the hospital inasmuch as it has learned to do so as a patient, as a visitor, or through hearsay. In other words, the community considers a hospital a reliable institution where patients will get the best possible medical care and, depending upon their class in society, a certain special attention either in education, luxury, or otherwise. They may expect too much of the hospital but, if so, let us show them through a good public relations program what they should expect and what we can give them so that, looking at the hospital, the community will be well informed and realize to what it is entitled when its members come into such an institution.

It is not the hours you put in that really count but what you put into those hours. — *Selected*

Public Health Nursing

The Child's Idea of What and How to Eat

FRANCES L. ILG, M.D.

Average reading time — 12 min. 48 sec.

IN THINKING OVER my experience in the guidance of children over the past fifteen years, I am rather pleasantly surprised to realize that the incidence of so-called feeding problems in children has steadily declined. Some kind of shift must have occurred to bring about this change. In my own professional training I recall instructions which were fairly cut and dried as to what, how much, and when to feed the baby. It seemed to me at the time that we too often lost sight of the child, that we were not giving enough consideration to *how* the child received the food we thought he ought to have. Mothers and nurses doggedly followed feeding instructions even when the child was trying to tell them how he felt about them. Fortunately, mothers (and some pediatricians) started to think for themselves and began to wonder if the child might not be speaking a truth. When we began to make a record of mothers' reports about feeding, we were frankly astonished to realize that a similar pattern would repeat itself in different children at the same age. As an example, the reduction in appetite in the second year of life following the more usual robust infant appetite was found not only in one child but in many children and, therefore, came to be expected.

The real shift in feeding practices has come because parents began to listen to their children. Today they also want and often have knowledge of what to expect. Thus, they are forewarned and can more easily accept their own child's demands as valid. I can think of many preschool children who might have developed real feeding problems under the old handling. They have their ups and downs, to be sure, but they are always supported by the understanding care of a mother who not only knows what to expect but also what to do about it.

Let us look into some of the demands which occur so repeatedly that finally we realized there might be some sense to them. I am going to start with twenty-one months of age, since more definite preferences occur at this age and also since this is a common age for feeding problems to begin. Some children of twenty-one months show such acute taste discrimination that they can tell the difference between one brand of canned food and another.

By two years of age, the child is beginning to name foods and, therefore, can give a better indication of what he wants. Also with his free use of the word "no," he can handle any refusals. Carrots and beets, especially carrots, are the more commonly preferred vegetables. Probably both color and sweetness are involved in this choice. Butter and cheese are also favored foods. As early as fifteen to eighteen months, a mother should watch out for the child who is going to take butter by the handful. Though he has little language equipment, he will call for "maw bu-bu" at two years of age. This preference for butter seems most marked up through two and half years of age. Interestingly enough, milk shows a rise at three years of age. What about our slogan of "a quart of milk a day," especially for the one-to-three-year-old when the child has gone off the bottle? Why not face the facts and consider the cheese and butter that many children are consuming when they may be refusing

their milk? I have cut the slogan down to "a pint a day."

At two to two and a half, when chewing is becoming quite well established, meat becomes a very real favorite. Crispy bacon, however, is often favored from one year of age and, in periods of low appetite, bacon usually stands secure and can be eaten day after day if the mother isn't too concerned about variety. Two and a half years of age is, indeed, a stage of real food jags, especially since the child demands the same food day after day. To serve stewed apricots day in and day out for a period of three months is truly hard on the mothers who think in terms of variety.

The age of three years marks a temporary break-up of the strong, over-channelized desires of the previous year. Desserts and sweets are now more desired. This is the first age when green vegetables are more acceptable, especially raw vegetables—raw carrots, raw beans, raw peas, and even raw potatoes. The child likes to chew these and often likes the taste better than when these same vegetables are cooked.

The four-year-old returns not only to food jags but goes on food strikes. It is a great pleasure to the mother when the child begins to relax at four and a half to five years of age and is less demanding and more amenable in accepting the foods that are on hand. But he clearly states that he likes plain cooking. Gravies, casseroles, and even puddings are often refused. Cooked cereal, which has often continued to be in disfavor from the lowered appetite period of the second year, is rather seriously refused at the age of five by even the few who may still be accepting it, unless it is fed by the mother.

Six shows even stronger preferences and refusals. One unfortunate experience with a certain food, such as a stringy texture or a rim of fat on the child's meat, might "put him off" that food for some time. The same type of thing happens in his adjustment to school. One unfortunate experience at school, such as being asked to count the children as he passes the crackers, when he doesn't know how to count very well, will be reason enough to refuse school. On the whole, he's "off" desserts, especially rice pudding and custards. This may be because he's not a very good "finisher" at six. But he won't starve. If he is just fed peanut butter and carrot sticks and then some more peanut butter and more carrot sticks, he will really do very well. This passion for peanut butter becomes even stronger at seven and eight.

By seven, the child will at least cooperate in gulping down a disliked food, hoping he won't taste it on the way. By eight, with his increased appetite and an increased venturesomeness, he is ready to taste almost any food. But he still doesn't like casseroles. One eight-year-old complained, "Why did they have to spoil that beautiful ham with that awful cream sauce?" Eight may refuse chicken if he has seen one killed, but he still doesn't like fat on his meat. I recently met an American mother married to a Swede who reported that this latter bit of information saved their household from a serious rift. The Swedish father wasn't going to let his eight-year-old son grow up a namby-pamby and was determined not to give in to the child's whim, even to the refusal of fat meat. The father calmed down when he saw the above statement in print and withdrew his objection.

By ten and eleven the child thinks about food, dreams of food, and in fact would like to eat all the time. The problem then shifts to the question of how to control the food intake. This problem may arise as early as eight years, especially with boys who become obese and are then open to much taunting from their contemporaries. Restricting them to one helping of each course may be all the control that is needed.

Respect for the choice of food is not, however, the only side of a successful eating pattern. How and where a child eats his meal is also an important part of eating. There are some children, especially boys, who demand to feed themselves, usually with their

fingers, at one year of age. They do an amazing job, messy as it is, and will accept no assistance. The fifteen-monther wants at least to dabble with his own spoon as he is being fed. Or, he likes his mother to fill his spoon and then wants to support the handle of the spoon himself as she helps to lift it to his mouth. By twenty-one months, the child may be so sensitive to peripheral stimuli—for instance, the sight of his dessert, the father coming home, and so on—that the distraction may not only interrupt but terminate his meal. That is why it is wise to feed him in his room at this stage—and on through three-and-one-half to four years of age with recurrent periods up to seven years.

Many people disagree with me on this. They feel that the child should learn to eat with the family group, and also that it is more work to feed the child in his room. Somehow they forget the wear-and-tear on themselves when a child is at the table.

Then comes the dawdling and necessary coaxing and cajoling of the two- to three-year-old. *If* the parents give up their meal hour to the children, success may be possible. But a family dinner is a complicated social situation often too much for the young child. His eating habits build up more smoothly when he is fed apart from the family group, and he often feeds himself better. The two-year-old may even want to eat alone in his room and may tell his mother to "go 'way." Some two-year-olds still need to be fed, and the "sweet eaters" may do better with a spoonful of dessert between the spoonsful of their main course. A few who are especially slow, dawdling eaters may eat better when they are read to or told a story. This does not mean that they need stories for all meals or for a prolonged time.

By two and a half years, certain rituals may be set up to which there is a need for adhering. An egg may be accepted at supper time but not at lunch. This is the age when between-meal snacks are in great demand. Some children eat more food between meals than at meal time, especially if these snacks consist of crackers, dried fruit, and fruit juices or milk.

By three and one half, the child is often ready and wants to come to a few family meals. Breakfast is often the best meal with which to start this pattern. By four, some eat better at the table than alone, but on the whole they have difficulty not to let their talking interfere with their eating. They do not sit well, and they invariably interrupt the evening meal with a trip to the bathroom which they have loudly announced. The four-year-old is ready to graduate from his room to the kitchen and is stimulated by his sense of promotion, but at five the child does better if he doesn't have too many meals with the family group. He usually feeds himself completely but may need help toward the end of the meal. Six is a frank menace both to himself and others at the family table, especially at the evening meal. He can't sit still, he swings his legs vigorously, he spills his milk, he eats with his fingers, and is usually sent away from the table when his father can't tolerate him any longer. But he relishes a tray in his room, especially by his radio, and eats peacefully and well.

From seven on he becomes a part of the family group. Eight not only eats more but he "wolfs" his food.

Now I would like to touch on some of the individually different eating patterns. We need to know more about the personality factors that go with the starch eaters, the meat eaters, and the sweet eaters. Then there are the spicy eaters—they are the ones who often hit real eating snags at two years of age. They are often petite girls with high emotional tone. Even as early as one year of age, a little onion juice may make bland mashed potatoes acceptable for such a child. One finds that they accept salty foods, strong cheeses, olives, salami, lobster, mushrooms, avocado pears, and spicy sauces on spaghetti. I do not advocate that they be given these foods exclusively. But when one sees poor feeding patterns being built up with a too-bland diet, one recognizes the pick-up value of an occasionally more stimulating diet. These children

also seem to eat better when they are given between-meal snacks. If children are too hungry, they won't eat. Often one finds that one or both of the parents of this type of eater has had a similar feeding history.

Be ready to listen to the child. He often talks more sense than we realize. He needs experience in eating as in everything else, but one should consider for what eating experience he is ready.

Habit-Forming Drugs

(*Continued from page 492*)

that the other substances of the Dolantin type, (Bemidone, Keto-Bemidone, NU-1196, NU-1779), should be noted for appropriate action when the 1948 protocol comes into force.

Methadone (*Amidone*)—The same provisions should apply to this drug and substances of similar chemical structure, on account of their habit-forming properties.

Precautionary measures with regard to synthetic substances—The committee was of the opinion that governments should watch with extreme care synthetic drugs of similar structure to those already examined, which may prove to have habit-forming properties. With reference to the experience already gained with substances of the Dolantin and Methadone groups, the committee recommended that any new convention should provide that substances of a particular chemical type, analogues of which have proved to be habit-forming, be placed under control until such time as they are shown not to be habit-forming.

Heroin (*diacetylmorphine*)—The committee expressed its alarm that, although the dangerous nature of heroin is now universally recognized, consumption of this drug has increased considerably in certain countries. Heroin is known to be more toxic than morphine, as its analgesic effect is from four to eight times more powerful. Its effect on the nervous system is much greater and 0.007 gr. of heroin is sufficient to induce respiratory paralysis. Over the last fifty years, heroin has caused great havoc in the world. It is strange to note that in some countries heroin continues to be widely prescribed, while others have completely ceased to use it. The committee was of the opinion that further information was urgently needed on the reasons for the continued use of considerable quantities of heroin in some countries. Such data might be obtained through the World Medical Association. In addition, direct inquiries might be undertaken on the spot by sending experts to ascertain, from local physicians and sickness insurance services, the reasons why this drug is prescribed in preference to others.

Morphan—The committee was informed that German and American chemists have produced, by direct synthesis, a compound known as Morphan, in which the structure of the naturally occurring morphine alkaloid has been very nearly attained. This difficult synthesis is not at the moment a commercial possibility, but the synthesis of other compounds related to morphine is going forward and the progress of this research should be watched very carefully.

Finally, the committee was impressed by the variety of names given to the same drug by different manufacturers. Indeed, to avoid ambiguity, it had been necessary to give the full chemical formula of these substances. The committee drew attention to the advantages which would result if each substance could be given a recognized name by some authoritative, and preferably international, body.

—*Chronicle of the World Health Organization, Feb. 1949*

Today public health is concerned with diseases that cannot be controlled without the effective participation of all the people. Our educational efforts must be broadened to include every individual in order that all may understand and act upon the principles of healthful living.

—Dr. Mayhew Derryberry

The habit of reading is the only one I know in which there is no alloy. It lasts when all other pleasures fade. It will be there to support you when all other resources are gone. It will be present to you when the energies of your body have fallen away from you. It will make your hours pleasant to you as long as you live.

—Anthony Trollope

Private Duty Nursing

New Procedures in Gynecological Nursing

ELIZABETH FERGUSON

Average reading time — 9 min. 36 sec.

GYNECOLOGICAL NURSING is a highly specialized type of nursing and demands many attributes in a nurse. She must be a good psychologist, have a thorough understanding of human nature, be the essence of patience, kindness personified, alert and adaptable to all her patient's needs. These qualities, while essential in any type of nursing, are even more important in gynecology, as "the gynecological patient often suffers more from emotional and nervous distress associated with her trouble than from the actual painfulness of her condition." For example, before going to the doctor regarding her particular problem, she may have heard all kinds of weird tales about the effect operations for "female trouble" have on the person afterwards. Some may have been told that the removal of some of their female organs will have a drastic effect on their sex life with a subsequent upsetting of their married life. Some women may still be in the child-bearing age and want more children and in some cases it may be necessary to make this impossible.

The nurse must have an appreciative knowledge of the anatomy of the female pelvic organs, the physiology of menstruation, and an understanding of certain conditions peculiar to women, as well as an actual knowledge of the specific condition involved and the probable course of the disease. "Knowledge which extends beyond the stereotyped page is imperative in the nursing care of the gynecological patient." She must consider the patients' problems and the individual differences that are likely to occur in the reaction of patients to the same condition. She must keep in mind that each patient is an individual, with her own physical, mental, and social problems, and not just another "case." Thus, with an appreciation of this background of knowledge of gynecological nursing, let us go on to some of the more recent changes in nursing procedures in this particular field.

Just as we must become adaptable to the individual differences in patients so we must adjust ourselves to changes in procedures. We will generalize, however, and study the gynecological patient who comes to the hospital for a vaginal hysterectomy under the present routine carried out by the gynecological staff of the Hamilton General Hospital. This type of operation affords us an opportunity to explain the newer trends in gynecological nursing procedures.

The patient is admitted to hospital and our first responsibility is to help her make a satisfactory adjustment to her new surroundings. We must see that the doctor's routine orders are carried out. Usually, a pelvic examination is made by the doctor shortly after the admission of the patient. While this procedure becomes commonplace to us, it may well be a source of embarrassment and considerable mental distress to the patient who has not been given some explanation and assurance beforehand. Everything possible should be done to protect the patient's natural modesty. In this way much can be done to help her over an embarrassing and somewhat frightening experience

Miss Ferguson is a member of the teaching staff of the Hamilton General Hospital.

and thus aid materially and psychologically in her recovery.

The patient is usually placed in dorsal lithotomy position and the articles required are:

A good light, speculum, tenaculum, packing forceps, sponge forcep, probe, uterine sound, gloves, draping sheet, lubricant, soap and water to cleanse patient.

At this time the doctor may also decide to do a "Papinacalou smear." This is one of the more recent methods for the early discovery of cancer of the uterus. While the method is not infallible nor 100 per cent correct, yet any new approach to the early recognition of cancer is of importance—"the earlier the discovery, the better chance of a cure." The equipment necessary for this procedure is the same as that for a pelvic examination, with the addition of the following articles: Test-tube containing solution 50% alcohol and 50% ether; pipette; glass slides.

Method: (1) By means of pipette aspirate some of the vaginal secretion; (2) place exudate on glass slides; (3) place slides in solution while still moist.

Should the laboratory report on this smear be negative, do not build a false sense of security, because a negative smear at one time is no indication the patient may not have positive smears in the future.

Another test the doctor may do at the time of the pelvic examination is the test for trichomonas. The same equipment is used with the *exception of the lubricant* and with the addition of a test-tube containing 5 cc. normal saline at room temperature.

Method: (1) Culture is taken from vagina with applicator; (2) placed in test-tube with normal saline; (3) taken to laboratory immediately with requisition.

The pelvic examination being completed, we proceed with the routine care. Instead of the old-fashioned vaginal douche given to clean up the cervix and vagina. we now insert a cream into the vagina both pre- and post-operatively. This cream has antiseptic as well as healing properties and is known as "Triple Sulfa Cream." It is a combination of: sulfathiazole, acetyl sulfanilamide, benzoyl sulfanilamide, urea peroxide, all incorporated in a water soluble adsorptive cream base. The method of insertion is simple and the equipment required is:

Cream, sterile applicator in sterile towel, paper bag, emesis basin, perineal pad, T-binder, green soap to scrub applicator after use.

It is essential the patient wear a perineal pad and binder during the course of the application of the "Triple Sulfa Cream." This procedure is usually carried out once daily for approximately eighteen days. Should the patient go home in a shorter period of time, she may take the applicator and cream home and carry out the procedure there. On the other hand, the patient may have started this treatment before coming to hospital.

In making the anesthetic bed, the nurse should always include in her equipment an intravenous stand. The intravenous solution should be on hand as well as the equipment essential for the drainage of a retention or in-dwelling catheter. The solution usually preferred for intravenous infusion is 5% dextrose in normal saline fortified with vitamin B. It should be kept covered as this vitamin deteriorates with light.

The patient usually returns from the operating-room with a retention catheter. This should be connected immediately; make sure drainage is established, watching the urine closely for any indication of bleeding. If there should be no retention catheter, the patient should be catheterized as often as necessary to keep her comfortable. This does not mean the proverbial q.8.h. At the time of removal of the catheter, which is usually three to four days, one ounce of ½% mercurochrome is instilled into the bladder. This acts both as an antiseptic and a stimulant. When the patient voids

after the removal of the catheter, she should be catheterized at least once to guard against residual urine.

The patient on her immediate return from the operating-room should be watched carefully for any abnormal bleeding. Abnormal bleeding of the gynecological patient has been known to take place as late as ten to fourteen days post-operatively. The cause usually is the absorption of the sutures before healing has taken place completely. This can often be rectified by rest, but if severe it may be necessary to pack the vagina, and even to transfuse the patient. The nurse should foresee this and have all the necessary equipment ready for the doctor. Packing is added to the equipment essential for a pelvic examination.

As soon as the patient can tolerate fluids by mouth, these should be started. This may be anywhere from six to twenty-four hours post-operatively. From then on the diet should be increased daily and the patient urged to eat, unless, of course, there is some contraindication such as persistent vomiting.

An enema of olive oil followed by a tap water cleansing enema is given the third or fourth day and then the bowels are kept open regularly. This is a marked departure from the old days when, following a vaginal hysterectomy or a perineorrhaphy, the knees were tied together, the patient allowed only fluids for a week, and no enema given for approximately ten days.

The care of the perineum has also undergone a radical change. No longer do we irrigate, but instead the perineum is washed daily with clean water and soap and dried thoroughly. This is a labor- and time-saving device and no doubt raises the question of infection in the minds of some. Over a period of two years we have yet to see an infected perineum.

Early ambulation is now practised. The patient usually gets up or sits with her feet over the edge of the bed twenty-four hours post-operatively. While this is usually carried out, it is well to check with the individual doctor even though it does appear in his standing orders. Of all the newer procedures in gynecology this is probably the one that presents the greatest problem. Some nurses still have misgivings about getting the patient up so early. However, we should accept it gracefully regardless of our own convictions. Much can be done to ease the discomfort of the patient getting up for the first time by administering a sedative a half to one hour beforehand. Early ambulation does help to prevent such post-operative complications as hypostatic pneumonia, thrombosis, etc. It aids the patient in expelling flatus and thus avoids many of those post-operative gas pains.

In the patients' daily bed care the nurse can do much to aid the physician in preventing phlebitis. During the time of the daily bath or while settling the patient for the night the Homan's test should be made. At the first indication of discomfort or pain in the leg or groin, report it to the doctor. He in turn may immediately give an anti-coagulant and in this way a severe phlebitis may be forestalled.

On the seventh day or thereabout, the patient is given a sitz bath which is then repeated daily. This has proven to be one of the most comforting of the newer procedures in gynecology. The position of the patient during this procedure increases the flow of blood through the pelvis, the heat increases the healing properties as well as being effective in the presence of inflammatory lesions—e.g., stitch abscess.

While these procedures are carried out by one group of gynecological surgeons, there may be individual differences. Again we emphasize that the nurse whether on the hospital staff or engaged in private duty must be adaptable both to her patients' needs and also to the doctor's requirements and orders.

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Aux Infirmières Canadiennes-Françaises

L'Orientation de l'Infirmière

ALICE GIRARD

Average reading time — 19 min. 12 sec.

Note: Pour répondre au désir exprimé par les infirmières nous publierons dans la page française du *Canadian Nurse* une série d'articles sur l'Orientation. Les travaux présentés lors du symposium à l'assemblée annuelle de l'A.I.P.Q. seront de ce nombre.

AVEC LES RAPIDES progrès de la psychologie moderne, on parle beaucoup de nos jours d'orientation. Les testes variés que cette science a mis à la mode nous ont convaincu que l'individu, pour s'épanouir et donner son plein rendement, doit déployer ses activités dans une sphère qui lui convient. L'orientation consiste à aider les individus à analyser leurs goûts, leurs besoins, et leurs aptitudes afin de découvrir où et comment ils peuvent donner leur pleine mesure avec le plus grand degré de satisfaction, tout en développant leurs capacités physiques, mentales, et intellectuelles. L'orientation ne consiste pas à résoudre les problèmes des autres, mais à les aider à les voir plus clairement pour les résoudre plus facilement.

L'étude de l'individu que l'on veut aider ou orienter doit porter sur son degré de maturité — mental, physique, et émotionnel—sur ses caractéristiques physiques, sa santé, sa personnalité, son degré d'adaptation, la nature et l'étendue de ses capacités, son comportement social, ses ambitions, ses qualifications, son expérience et son entraînement. Ceci démontre clairement le danger qu'il y a de s'instituer *conseiller à tout hasard* sans connaître à fond l'individu; ici la bonne volonté ne suffit pas, il faut des connaissances. On fait maintenant une carrière de l'orientation et celle qui s'y voue doit avoir un grand nombre de qualités sociales — tact, patience, courtoisie, humeur — mais avant tout elle doit être foncièrement intéressée à l'individu et à ses problèmes, car pour aider quelqu'un efficacement il faut comprendre et partager les goûts et les aspirations de cette personne, et faire nôtre ses problèmes.

Si nous prenons comme sujet d'orientation une infirmière qui vient de terminer son cours, nous voyons qu'elle a un choix varié d'activités au sein même de l'hôpital: département de maternité, de pédiatrie, dispensaires, salle d'opération, etc. Pour l'infirmière qui veut poursuivre des études et se spécialiser, l'hôpital offre encore dans le nursing proprement dit, des champs d'action qui se développent depuis quelques années avec une rapidité prodigieuse au point de vue nursing — c'est la psychiatrie et l'orthopédie. Pour celles que le contact direct des malades intéresse moins, les carrières de diététiste, de statéticiennes, de technicienne de laboratoire, de radiologie ou de physiothérapie, peuvent répondre à un grand nombre d'aptitudes variées. L'hôpital offre encore un champ intéressant dans l'enseignement et l'administration. Le sanatorium et l'hôpital pour maladies contagieuses aiguës offrent les mêmes activités dans une ambiance quelque peu différente.

La jeune graduée, qui n'a pas encore eu l'occasion de décider vers quel champ d'action elle veut évoluer, trouvera à l'hôpital l'occasion d'acquérir de l'expérience additionnelle. Il arrive souvent que, libre de la préoccupation des cours à suivre, elle

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retire infiniment plus de satisfaction de son travail que lorsqu'elle était étudiante. N'étant plus soumise à l'exigeance du curriculum elle peut se faire transférer dans divers services jusqu'à ce qu'elle ait trouvé le genre de travail qui lui convient. Pour celles qui désirent se faire une carrière dans le service hospitalier, il est à conseiller de vivre au dehors de l'institution. L'infirmière qui travaille et vit dans le même atmosphère pendant des années est apte à voir ses intérêts se restreindre et sa personnalité s'atrophier à moins d'un effort constant pour se sortir du milieu. Il semble de plus en plus facile de suivre ce conseil à mesure que les heures de travail des infirmières hospitalières se raccourcissent et que la rémunération augmente. L'infirmière n'est plus obligée comme autrefois de vivre à l'hôpital à cause de la modicité de son salaire.

Pour l'infirmière qui aime à garder son indépendance, le service privé peut répondre dans une certaine mesure à ce goût. Il est évident que quand on a choisi une carrière telle que celle d'infirmière on n'est jamais vraiment indépendant, mais l'infirmière en service privé peut à son gré prendre ou refuser un cas, s'accorder une période de repos plus ou moins longue entre chaque cas, et même choisir ses heures de travail à l'époque de la journée qui lui convient. Ce genre de nursing offre encore beaucoup d'avantages entre autre celui de permettre à l'infirmière de développer son initiative, de prendre une large part de responsabilité, de profiter d'une variété de conditions de travail; mais, par contre, la stabilité de son emploi est sujette à divers facteurs favorables et défavorables tels que la fluctuation des conditions économiques, l'expansion des hôpitaux, le développement des plans d'assurance santé ou d'assurance maladie, et les progrès modernes de la médecine.

Vient ensuite le nursing en hygiène publique qui a pris ces dernières années une expansion considérable et qui, selon toute probabilité, va continuer à absorber pour plusieurs années encore un nombre croissant d'infirmières. Le public mieux informé sur la question santé favorise de plus en plus le développement des diverses organisations qui s'occupent de maintenir et de promouvoir la santé, non seulement de l'individu mais de la famille et de la société. Il est surprenant de constater le grand nombre d'infirmières qui se dirigent vers cette carrière sans trop savoir au juste en quoi consiste les fonctions de l'infirmière hygiéniste, mais uniquement parce que l'on est fatigué du soin des malades à l'hôpital ou en service privé et que ceci semble offrir plus de diversité. Qu'il soit dit d'abord que l'infirmière hygiéniste a assurément un genre de travail des plus intéressants, mais que l'on se garde bien de le choisir en pensant qu'il est moins fatigant et plus facile que tout autre. L'infirmière hygiéniste doit avoir une bonne santé car, à quelque organisation qu'elle appartienne, elle devra braver la température en toute saison, couvrir quelques milles de territoire, monter et descendre plusieurs escaliers, respirer assez souvent l'air insalubre des taudis, etc. Elle doit aimer les gens, s'intéresser à leurs problèmes, s'adapter facilement, pouvoir prendre des responsabilités et montrer de l'initiative. Elle doit être par-dessus tout une éducatrice car c'est là son rôle principal. En hygiène publique, l'infirmière a le choix entre les organisations officielles — services de santé, unités sanitaires, etc.— où son travail consiste principalement dans l'éducation du public et la surveillance de la santé; et les organisations privées où, en plus de l'enseignement, l'infirmière donne des soins au chevet à domicile. Dans l'un ou l'autre cas, le travail de l'infirmière hygiéniste ne manque pas de diversité et ceci compense largement pour l'énergie déployée. Depuis le bambin de trois ans qui lui crie dans la rue: "Bonjour Margalade!", la fillette qu'elle renvoie de l'école avec des signes de rougeole, la mère qu'elle visite pour la convaincre de l'importance de la correction d'une défectuosité physique chez un pré-scolaire, la femme enceinte qu'elle dirige vers

son médecin et avec qui elle trace un budget familial comprenant une diète balancée pour six avec $25 par semaine, jusqu'au vieillard à qui elle explique ce qu'il faut faire pour obtenir sa pension de vieillesse, l'infirmière hygiéniste peut dire que ses activités s'étendent souvent dans la même journée du berceau à la tombe.

Si notre jeune infirmière n'a pas encore trouvé dans cet article le travail qui lui convient, nous pouvons encore lui offrir le nursing industriel lequel comprend, contrairement à ce que pense beaucoup d'infirmières, infiniment plus que des pansements d'urgence, puisqu'une analyse du travail d'une infirmière de ce genre dans une industrie considérable et bien organisée peut comprendre au delà de quarante genres d'activités différentes.

Il y a encore le travail d'infirmière dans un bureau de médecin ou de dentiste, et celui d'hôtesse à bord d'un avion. Dans ces deux situations, l'infirmière trouvera moins d'occasions d'utiliser ses connaissances professionnelles car l'une et l'autre peuvent souvent être remplie de façon satisfaisante par une personne non qualifiée comme infirmière. Au moment où la pénurie d'infirmière se fait si lourdement sentir, l'infirmière doit considérer qu'il est de son devoir de servir là ou elle peut rendre le plus de service à sa profession et à la société.

Il se peut que notre jeune infirmière reste perplexe devant tant d'opportunités et qu'elle se demande encore quoi choisir. Nous pourrions alors borner notre conseil à ceci: "*Choisissez avant tout un travail qui vous plaît en tenant compte des qualifications qu'il demande.*" Il est bon d'insister à ce point sur les qualifications car la profession se montre de plus en plus exigeante à ce sujet et l'infirmière qui aura négligé d'en tenir compte s'expose à subir plus tard de grandes déceptions.

On peut diviser les qualifications de l'infirmière en deux catégories: éducationnelles et professionnelles. Par qualifications éducationnelles on entend le degré d'instruction primaire, supérieure, ou secondaire que l'on exige de l'infirmière avant de l'admettre à poursuivre des études professionnelles. Ainsi la jeune fille qui aspire à devenir infirmière doit avoir comme minimum d'instruction un certificat de onzième année scolaire. Ceci lui permet tout juste d'être admise à l'étude de la profession. Une fois diplômée, elle sera peut-être surprise d'apprendre que ceci n'est pas suffisant si elle désire poursuivre ses études professionnelles pour atteindre un baccalauréat en quelques branches du nursing. On lui demandera alors une douzième année ou l'immatriculation senior. Quant aux qualifications professionnelles, elles varient selon la position que l'on veut atteindre dans le nursing. L'infirmière qui a terminé même de façon brillante son cours d'infirmière n'est pas pour cela qualifiée comme professeur de nursing. Pour être qualifiée en hygiène publique, l'infirmière doit poursuivre une année d'étude dans cette branche et davantage si elle aspire à une position administrative.

Les qualifications professionnelles comprennent en plus des études professionnelles, l'expérience que l'on acquiert avec le travail. Un baccalauréat en hygiène publique ne rend pas une infirmière qualifiée à un poste de commande dans une organisation de ce genre car ceci ne répond qu'à la moitié des qualifications exigées lesquelles comprennent également un minimum d'années d'expérience.

L'infirmière avertie doit donc tenir compte que dans notre profession l'on devient de plus en plus exigeant au point de vue des qualifications. A mesure que l'on enlève à l'infirmière des tâches qui ne sont pas strictement professionnelles, on crée le besoin d'un groupe d'aides pour remplir ces tâches. De l'infirmière professionnelle ainsi libérée de tout ce qui n'est pas strictement nursing, on exige une préparation plus scientifique et portant des études plus poussées. Aux Etats-Unis, on commence déjà à supprimer les études professionnelles post-scolaires d'une année conduisant à un certificat pour acheminer l'infirmière immédiatement vers le baccalauréat. Les rapports Brown et

Ginzberg contiennent des recommendations à cet effet et malgré que nous soyons parfois lents à emboîter le pas de nos consoeurs américaines dans leur course vers le progrès, il ne faut pas oublier que nous prenons là une large part de nos directives et de nos standards professionnels.

De tout ceci une conclusion semble s'imposer. L'infirmière qui sort de son école avec son diplôme et qui désire se faire une carrière dans le nursing n'est qu'au seuil de cette carrière professionnellement parlant. Quelle fasse un an ou deux de nursing général comme expérience de base et pour l'aider à faire un choix plus judicieux du genre de service qu'elle veut choisir et après avoir fait ce choix, si ce service demande des qualifications spéciales, qu'elle n'hésite pas à faire tout son possible pour acquérir ces qualifications si elle veut s'éviter pour plus tard de cruels regrets et se préparer une carrière intéressante.

National Cancer Institute

Grants of the Institute for fundamental research on cancer in Canada have increased from $84 thousand to $225 thousand over the last three years, it was announced at the third annual meeting of the National Cancer Institute of Canada, held recently in Ottawa.

Satisfaction was expressed with the progress of the fundamental research program. One of the newer phases of this program is the attention now being given to ways and means by which cancer hazards in certain Canadian industries might be studied.

To aid in the diagnosis of unusual tumors and to act as a central collection agency or tumor library, a Canadian Tumor Registry is being set up in Ottawa. This utilizes the technical facilities of the Federal Laboratory of Hygiene. Dr. Desmond Magner, professor of pathology, University of Ottawa, is acting as registrar and a committee of consultants has been appointed, consisting of six outstanding Canadian pathologists. The registry is of special service to pathologists working in laboratories isolated from the larger medical centres.

The National Cancer Institute and the Canadian Cancer Society are affiliated in all complementary fields of endeavor.

By *Chuckles* P.R.N.

A patient's room should be aired out so that the air inside will get in touch with the air outside.

Religious care should be given to a patient's back to prevent bed-sores.

Insomnia is a handicap some people possess.

The hands are efficient disease carriers.

Deceased tonsils should be removed.

Certified milk is milk from cows that have been government-tested and then put in bottles and sold.

Warm the eye-drops by placing the bottle in the patient's axilla for a few minutes.

When sore feet develop, see a good pedestrian.

Library Gifts

The National Committee for Chile is now receiving gifts for the library of the Medical School of the University of Chile at its new collection centre—*Room 318, Library of Congress, Washington, D.C.* The newer materials in the library, including periodicals, books, and reference materials, were totally destroyed in the recent fire. Medical periodicals of the last ten years and recent medical books are urgently needed. Your contribution will be appreciated.

Provincial Directory

The Alberta Association of Registered Nurses is to be congratulated on the smart appearance of their *Provincial Directory and Manual, 1949*, which has recently been published. In addition to having a complete list of association members and their addresses, Editor J. Frances Ferguson has incorporated much useful information into this handy 68-page issue. The bulletin has been given wide distribution, not only to nurses and doctors but also to principals and teachers.

Nursing Profiles

Mary M. Roberts, who became editor of the *American Journal of Nursing* in 1921 and, following re-organization of the *Journal's* staff in 1947 was named "Editor-in-Chief," has retired. Though it has been the privilege of few Canadian nurses to know Miss Roberts personally, the influence which she exerted on the thinking and planning of nurses in the United States has gone far beyond the confines of her own country. It is reflected in the ever-widening professional developments in Canada and throughout the world. Her rich experience in the interpretation of every aspect of nursing endeavor has provided a pattern for other nursing periodicals, including our own.

A native of Cheboygan, Mich., Miss Roberts is a graduate of the Jewish Hospital School of Nursing in Cincinnati, Ohio, and of Teachers College, Columbia University. There is in her professional experience an unusually rich variety.

After a period as clinic nurse at the Baroness Erlanger Hospital in Chattanooga, Tenn., soon after her graduation, she became superintendent of nurses at the Savannah Hospital, Georgia, where she organized and directed the school of nursing. Her own hospital, however, soon recalled her to Cincinnati to become assistant superintendent and for a year acting superintendent of the Jewish Hospital.

Following this a period of private duty nursing in Evanston, Ill., intervened before she became acting supervisor, for a brief period, in the obstetric department of the Evanston Hospital. The Christian R. Holmes Hospital in Cincinnati next sought her services and she was superintendent of that institution until World War I called her to other duties.

Bradford Bachrach

MARY M. ROBERTS

During that war, Miss Roberts was appointed director of the Bureau of Nursing, Lake Division of the Red Cross. Here she was responsible for directing the recruitment of the hundreds of nurses "requisitioned" from this area for service with the armed forces. She next reported for military duty as a reserve nurse to direct a unit of the Army School of Nursing. On October 4, 1918, she entered the Army Nurse Corps and became chief nurse, continuing in both positions until she received her discharge on September 8, 1919.

By the war's end, Miss Roberts had already given nearly twenty years in the service of nursing. But her greatest contribution—as editor of the *American Journal of Nursing*—was still before her. Two years of study at Teachers College, Columbia University, followed immediately on her discharge from the army; she received the B.S. degree and a diploma in the administration of nursing schools in 1921.

As editor, Miss Roberts' devotion to the interest of nurses has not been confined to the technicalities of directing the policies and program of the *Journal.* She has been constantly alert to grasp every opportunity to encourage nurses to develop broader concepts of service to patient and community; she is also deeply concerned for the welfare of the individual nurse. To these ends she has travelled extensively in the United States and abroad, studying and observing nursing and making friends with nurses the world over. Nurses are extremely fortunate in having had, as editor of their professional magazine, a nurse so well informed and far-sighted, with a rare gift for writing, plus the business acumen needed for directing so large an enterprise as the *Journal* has become under her administration.

The Mary Adelaide Nutting award, given by the National League of Nursing Education for outstanding contributions to the advancement of nursing, both in United States and abroad, was presented to Miss Roberts at

the first general session of the fifty-third convention of the N.L.N.E. held in May, 1949. Miss Roberts is the third person to receive the award and the only non-educator.

Although Miss Roberts is relinquishing the duties of editor-in-chief, she is not retiring from the field of nursing—or even from the *Journal* offices—but has been asked by the *Journal's* Board of Directors to undertake a special piece of writing.

Congratulations of Canadian nurses are being extended to **Lyle M. Creelman** who has been appointed nursing consultant in Maternal and Child Health with the World Health Organization. Miss Creelman's headquarters will be in Geneva.

Born in Nova Scotia, of Scottish descent, Miss Creelman is a graduate of the Vancouver General Hospital. She holds her B.A.Sc. (nursing) degree from the University of British Columbia. In 1938 she was awarded a Rockefeller Fellowship for post-graduate study in administration and supervision in public health nursing. The following year she secured her M.A. from Teachers College, Columbia University.

Experience as a staff nurse and supervisor preceded Miss Creelman's appointment in 1941 as director of public health nursing with the Metropolitan Health Committee, Vancouver. She resigned from this position in 1944 to join the staff of UNRRA and was named chief nurse in the British Zone of Germany. She returned to Canada in 1946 and engaged in survey work with the British Columbia Department of Health and Welfare. Recently, she has completed a very extensive study of public health nursing practices in Canada, under the auspices of the Canadian Public Health Association.

Miss Creelman's sound counsel and leadership will be missed from our professional association. For the past year she has been third vice-president of the Canadian Nurses' Association and chairman of the Finance Committee. Previously she had served as chairman of the national Public Health Nursing Section. She had also been very active in the Registered Nurses' Association of British Columbia.

Macho, Toronto

LYLE CREELMAN

Our good wishes go with Miss Creelman in this important new assignment. She will doubtless find time to indulge in her favorite pastimes of walking and cycling and we look forward to seeing the photographs she will surely take as she travels.

Myrtle I. Graham, former director of nursing at Toronto Western Hospital, has been appointed to that position at the Ontario Hospital, St. Thomas. Graduating from the Winnipeg General Hospital, Miss Graham held her first positions as head nurse, later as medical supervisor in her home school. Post-graduate work in teaching and supervision was taken at McGill School for Graduate Nurses. In 1940, Miss Graham became assistant and later director of nurses at Verdun Protestant Hospital, Que., going to T.W.H. in 1945.

In Memoriam

Sara (MacVean) Burns, who graduated from Bellevue Hospital in New York, died in Victoria on April 1, 1949, at the age of seventy-six. At the outbreak of the South African War in 1899, the Society of American Ladies resident in London, Eng., offered a completely staffed and equipped hospital ship to care for British wounded. Mrs. Burns was

one of the nursing staff aboard this ship and is believed to have been the last surviving member.

* * *

Victoria (Ryde) Currie, a graduate of the Guelph General Hospital, died suddenly in Port Arthur on April 4, 1949. Prior to her marriage in 1924, Mrs. Currie had followed her profession for a number of years in Guelph.

* * *

Margaret Ann Curtin died in Ottawa on March 29, 1949, following a brief illness. Miss Curtin graduated from St. Joseph's Hospital, Syracuse, N.Y., and was with the Victorian Order of Nurses until 1939 when she retired.

* * *

Reita Frances (Burns) Keith, who graduated from St. Mary's Hospital, Timmins, died on March 23, 1949, in Toronto at the age of forty-one.

* * *

Elizabeth O'Leary, who was a member of the first graduating class of St. Michael's Hospital, Toronto, in 1894, died on April 12, 1949, in Toronto, at the age of seventy-nine.

* * *

Katherine Charlotte Prest, a graduate of the Niagara Falls General Hospital in 1917, died in Niagara Falls on April 14, 1949, at the age of seventy-three.

* * *

Mary Jessie Reay, who graduated from the Edmonton General Hospital in 1913, died in Kelowna, B.C., on March 23, 1949, in her fifty-ninth year.

* * *

Henrietta A. Shipley, a graduate of Victoria Hospital, London, Ont., and for twenty years matron of the Katherine H. Prettie Hospital in Bonnyville, Alta., died in New Westminster, B.C., on January 19, 1949. Miss Shipley graduated in 1900 and her first position was night supervisor at the Victoria Hospital. She then went to the United States and was engaged in private nursing in San Antonio and Saratoga Springs. She served overseas with the American Red Cross during World War I and on her return did post-graduate work in public health in Toronto. In 1921 she accepted a position with the W.M.S. and went to Bonnyville and organized a hospital there where she remained until she retired in 1941. She saw the hospital in Bonnyville grow from a few beds in a farm-house to the modern building that is there today.

AGNES TANNEY

* * *

Margaret Gertrude Small, who graduated from Toronto General Hospital in 1917, died in Toronto on April 9, 1949, following a long illness.

* * *

Agnes Tanney, one of Saskatchewan's well-known nurses, died April 15, 1949, of heart ailment. Mrs. Tanney graduated in 1922 from Regina Grey Nuns' Hospital. During twenty-three years as nurse in the provincial Department of Public Health, she travelled extensively throughout the province organizing health and nursing services. Four years ago she retired and since has been doing special nursing. From time to time she had served on the executive of the Saskatchewan Registered Nurses' Association.

* * *

Georgina (McPherson) Winney died in Collingwood, Ont., on April 18, 1949, at the remarkable age of 103 years. She had been ill for a short time only. Mrs. Winney, whose father was a physician, graduated from the Kingston Hospital at the age of twenty-two. After nursing on the staff there, she moved to the United States where she engaged in private nursing for several years. She was married in 1871, her husband predeceasing her by twelve years. Mrs. Winney was best known in recent years for her expert needlework. One of her greatest achievements was the completion of twenty-two differently designed crocheted bedspreads. She carried on her needlework until her eyes failed her at the age of one hundred. Recently on the occasion of her 103rd birthday she enjoyed a party at which she welcomed several hundred callers.

Trends in Nursing

Average reading time — 11 min. 12 sec.

First Call

"The time has come, the walrus said
To speak of many things,
Of shoes and ships and sealing wax
Of cabbages and kings . . ."

and like the walrus, National Office must begin to speak about the program for the next biennial meeting. June, 1950, looks a long distance off but how time does slip up on us!

The program that is to be planned for the next biennial is *your* program and you will want it to be the best ever. What can National Office do to assure you the type of meeting you want?

At the close of the Conference in June, 1948, the nurses of Canada indicated their desire for a program that would again feature "Workshops." But *what are the topics you wish to study?* That is the question that must be answered for the Program Committee. Would you give this subject your attention and let us have some directives that will enable National Office to plan with you for the 1950 meeting in Vancouver.

Support of Nurse Recruitment

We expect in the near future to have some very attractive literature for recruiting. The Department of National Health and Welfare has very kindly offered to support the Canadian Nurses' Association recruitment program by assuming responsibility for printing the nursing bulletins, now in the process of revision. Do you know the booklet "What You Want to Know about Nursing"? This booklet gives the prospective student information on requirements, standards, way of life, opportunities, and closes with suggestions for the young student not yet old enough to enter a nursing school. It is a really comprehensive little book. It presents nursing as a worthwhile career which offers abounding opportunities to the wide-awake young woman. To quote from the little yellow book:

> In no other work can a woman give such full and meaningful expression to her talents or do so much for others. For this reason nursing is more challenging than any other work. Nursing is not just a means of earning your own living, it is a way of helping others to live—it is a really worthwhile work.

When recruiting we may have tended to underestimate the opportunities in nursing. We know that we are graduating more nurses every year, yet many positions in nursing are unfilled. Perhaps this aspect of growing opportunity to do important, interesting work while at the same time earning a living, will appeal to the young idealistic student rather than the nursing schools' need for students. Why should a young girl have any interest in a school's need for students?

Have you helped your community to understand what adequate nursing means to them, why it is needed, and how they can help by interpreting opportunity and need? Do you plan joint all-year-round programs that keep interest alive? The following facts and figures collected from schools across Canada will give you some idea of the Canadian nursing picture:

Data collected from questionnaires sent out to schools of nursing in February, 1949, on student enrolment for the year 1948 give the following information: On December 31, 1948, there were 13,279 students in training, an increase over the previous year of 407. The number expected to graduate in 1949 is 3,991, an increase of 129 over the previous year. These figures are the highest on record and top a steady increase in enrolment and graduates over the years except for one year. In 1945, there was a decrease of students enrolled and an even greater decrease of new graduates in 1946, but the following years both these figures were upped by about

seven hundred and, since then, the climb again has been steady and less spectacular. At present in Canada, there are 170 schools of nursing.

Assessing Values

The Department of Labor news release, April, 1949, notes that a large number of graduates of European universities, who have been working in Canada's basic industries, have completed their period in selected employment and raises the question of the responsibility of the state to place these people in employment for which they are best suited. The Employment Committee, under the chairmanship of Mr. Justice W. J. Lindal of Winnipeg, agreed "that there should be a uniform method in Canada of assessing the value of training in the various European schools of learning." While the nurses coming to Canada are not as a rule university graduates, they have had professional education and we should not fail to make use of trained minds and hands. Should the nursing profession give thought to a uniform method of evaluating the training in European nursing schools?

Qualifying for Service

Miss Janet Geister, in the April number of *R.N.*, comments in her usual forthright manner on "The New Look in Nursing." Miss Geister seems to feel that the average nurse is realizing the need for organization, questioning what organizations can and must do, increasing her critical faculties and looking to nursing leaders to present an understandable program of action centring around "good nursing care as much as around good care of nurses." The article offers constructive suggestions for democratic leadership that will base practice on known needs and capacities of the average nurse, debunks the infallibility of so-called leaders, and outlines the responsibilities of board and committee members. She states:

> Holding office or committee appointment inevitably means the possession of power, and the possession of power is a test of character. Serving is not only a matter of our willingness to work, but our willingness to qualify for the work . . . Nurses know today that big issues are at stake. They realize that these issues are in the hands of their trustees, and their New Look at these trustees is cool, critical and, yes, sometimes unjust. The nurse who accepts leadership or aspires to it must take the bitter with the sweet. It is all part of a satisfying and rather wonderful service in a highly useful profession.

In-Service Education

Rapid staff turnover and the scarcity of fully qualified personnel for nursing appointments in the hospital or public health nursing field focuses attention on in-service educational programs. The March number of *Public Health Nursing* carries a series of articles devoted to staff education. The principles and practices outlined, while developed primarily to satisfy the need of public health nursing organizations, might well be applied, with slight adaptations, in the hospital situation. To quote from the editorial—

> Miss Dorothy Wilson bases her principles of staff education on three factors: first, staff education is one means by which the nursing agency seeks to attain its ends; second, staff education is planned for adult workers who, although they may vary in their professional development, participate in a joint undertaking; and, finally, staff education is but one aspect of all education—education for living and working.

The second article in the series, "The Supervisor as Counsellor," seeks to develop the principle of shared experiences and evaluation as basic and deals with the introduction of the new worker to the job, individual guidance through the supervisory conference on individual patient problems, and touches upon the need for developing skill in interpersonal relationships whether through the written or spoken word. The article closes with the following quotation:

> The nurse should develop an increasing

capacity for self-help and the teacher guide an increasing willingness to allow the assumption of graduated responsibility as quickly as the nurse can carry it.

There follows an article on visual education, then one entitled "On-the-Job Training" and, finally, "Building Expertness in a Clinical Field." This article discusses the use of the pre-test, the development of the program, the final evaluation and recommendations.

Long-Term Patients

If you are interested in the care of patients suffering with chronic illness, you will find a very informative and sympathetic exposition of the problem in the April issue of *The Canadian Hospital*. The article suggests a solution on three fronts: first, prevention; second, control, prevention of further disability, and rehabilitation through provision of treatment facilities for all who require it; third, that the care provided be good care whether the patient is in the curable or incurable stage of illness. The difficulties in the way of defining a program which will achieve the above objectives are outlined. The place of research and professional education, the nature of the problem, type and number of facilities and services required, and the human elements involved in planning are all discussed. Miss Nicholson says:

> The diagnostic and treatment services necessary for the care of chronically ill patients are, in general, the same as those required in the care of any other sick people.

She questions the desirability of duplication of facilities and specialized staff made necessary by setting up two types of hospitals—one for acutely ill and another for the chronically ill patient—and makes the statement that Dr. Bluestone and others experienced in this area strongly urge—

> That we stop thinking in terms of separation between the acutely ill and chronically ill, and begin to recognize the general hospital as the centre where specialized services should be provided for all types without arbitrary distinction.

She closes with an appeal for efficient use of hospital beds and intelligent community planning, tempered with understanding of the underlying human tragedy.

New Methods of Teaching

The Bureau of Current Affairs, London, England, is conducting courses in "Discussion Methods." Two nurses, who attended with a group representing the army, the university, industry, Borstal Institutes, etc., report on this experience in *Nursing Times*, April 16. The Bureau of Current Affairs is an independent, educational body, non-profit making and free from government control, and was established in 1946 by the Carnegie United Kingdom Trust in the belief "that democracy depends on discussion and that responsible discussion depends on having the relevant facts." The courses are planned for small groups, not more than twelve in number, and afford opportunity for participation through which new techniques are acquired. The nurses reporting mention three factors as necessary for successful discussion:

> First, the interest of the group must be maintained throughout; second, the leader must have the actual facts on hand for reference; and, third, the control of the whole group is the keynote to good discussion.

These nurses were impressed with the evidence of preparations for the institute, the purposeful activity, the potentialities of group versus individual thinking, the ease with which individuals from different spheres met on common ground, and the practical application of evaluation. One nurse asks, "Should not the use of discussion methods be extended much more fully in hospitals and health spheres where constructive work is now so urgently required?" and closes with: "In my opinion, the courses now arranged as preparation for

tutor, ward sister, or administrator should include methods for discussion group leaders." Such a course should also be stimulating for those already holding positions of responsibility in hospital and health service.

Assistance to Students

The following excerpt is from the report of the Department of Labor for fiscal year ending March 31, 1948:

The Youth Training Agreement, which provides for assistance to students, was again in effect in all provinces. This is the most extensively used of all the youth training schedules. Persons eligible for assistance are *nurses in training* at hospitals and students who are in a course leading to a degree at a university and who have good academic standing, but who cannot continue their course without financial assistance. Each province decides whether the assistance takes the form of a loan, an outright grant, or a combination of the two. This feature of the grant makes the nursing profession an attainable goal for young women who really desire to become nurses and would be unable to take the necessary training without financial assistance.

Orientation et Tendances en Nursing

PROGRAMME BIENNAL, 1950

Le temps fuit comme l'ombre . . . a dit le sage. Sans vouloir nous rappeler la rapidité de nos jours, l'Association des Infirmières du Canada doit penser à la préparation du programme biennal de 1950. Ce programme est préparé pour vous et par vous; en effet, pour répondre au désir exprimé par un grand nombre d'infirmières lors du congrès de 1948, des cercles d'études seront de nouveau organisés, *mais sur quels sujets?* Voilà la question que vous pose le Comité du Programme. Voulez-vous y penser, en parler immédiatement à votre entourage et envoyer vos suggestions au secrétariat.

POUR AIDER LE RECRUTEMENT DES ELÈVES-INFIRMIÈRES

Nous nous attendons, prochainement, de recevoir des bulletins très attrayants concernant le recrutement des élèves-infirmières. Le Ministère National de la Santé et du Bien-Etre a généreusement accepté d'appuyer le programme de recrutement de l'A.I.C. et a pris l'engagement d'imprimer à ses frais les bulletins sur le nursing déjà publiés par l'A.I.C. et actuellement sous revision.

Connaissez-vous la brochure intitulée "What You Want to Know about Nursing?" Cette brochure sera traduite en français au secrétariat de l'Association des Infirmières de la Province de Québec. Cette brochure s'adresse aux élèves des pensionnats et écoles —futures candidates infirmières. On y donne des renseignements sur les conditions d'admission dans les diverses provinces sur la vie d'une élève-infirmière, et les carrières ouvertes aux membres de la profession. Des suggestions très précieuses sur l'emploi du temps sont faites à la jeune fille qui n'a pas l'âge requis d'admission à une école d'infirmière.

C'est une belle étude, accessible aux jeunes filles d'âge scolaire. La profession d'infirmière y est représentée comme une carrière de valeur, offrant de nombreux avantages. Voici un extrait de ce petit livre jaune: "Dans aucune autre profession une femme peut faire valoir ses talents à un si haut degré ou être aussi utile aux autres. C'est pour cette raison que la profession d'infirmière donne plus de satisfaction que tout autre. L'infirmière, tout en gagnant très bien sa vie, aide aux autres à vivre. C'est un travail qui donne du contentement."

Lorsqu'on parle de recrutement, il arrive que l'on n'estime pas à sa juste valeur les différentes carrières offertes aux infirmières. L'on sait que le nombre des infirmières diplômées augmente chaque année, mais que malgré celà il y a encore un grand nombre de positions disponibles pour les infirmières.

Si l'on présente aux jeunes filles les positions disponibles où l'on réclame des infirmières, il se peut qu'elles soient beaucoup plus intéressées à devenir infirmière, en pensant qu'elles peuvent avantageusement gagner leur vie, tout en étant utile. Pourquoi présenter aux jeunes filles que les hôpitaux ont besoin d'élèves-infirmières? Ce n'est pas là leur problème et l'intérêt personnel, même

chez la plus généreuse des jeunes filles, ne doit pas être oubliée.

Dans votre milieu, avez-vous fait comprendre à votre entourage ce qu'une infirmière présente de sécurité sociale pour eux et leur avez-vous fait connaître les besoins de la société?

Voici quelques faits intéressants concernant les écoles d'infirmières au Canada. Ces renseignements nous ont été fournis par les écoles d'infirmières en réponse à un questionnaire envoyé en février 1949: Le 31 décembre 1948, il y avait 13,279 élèves-infirmières, 407 de plus qu'en 1947. L'on graduera en 1949, 3,991 infirmières, 129 de plus que l'année précédente. Ces chiffres représentent le nombre le plus élevé jamais atteint et montrent une augmentation annuelle, sauf pour les années 1945 et 1946 où il y a un déclin dans le recrutement mais la côte fut vite remontée—700 élèves se sont inscrites depuis et l'augmentation se maintient. Au Canada il y a actuellement 170 écoles d'infirmières.

Valeurs Disponibles

Le Ministère National du Travail, dans un bulletin de nouvelles paru en avril 1949, fait remarquer que, parmi les personnes déportées qui actuellement terminent leur année de travail obligatoire dans les différentes industries du pays, il se trouve un grand nombre de diplômés d'université, et il présente pour l'état la responsabilité de placer ces gens comme il convient. Le Comité de Placement, sous la présidence du Juge W. J. Lindal de Winnipeg, est d'avis qu'il devrait exister une méthode uniforme au Canada permettant d'évaluer la formation donnée dans les diverses écoles européennes.

Bien que les infirmières d'Europe, venues au Canada, ne soient pas généralement des diplômées d'université, elles ont tout de même reçu une formation professionnelle et il ne faudra pas manquer de faire un bon usage de ces cerveaux et de ces mains bien disciplinées.

La profession d'infirmière devrait-elle aussi songer à une méthode uniforme d'évaluation permettant de juger de la formation donnée par les écoles d'Europe?

La Nouvelle Ligne—1949

Connaissez-vous la ligne à la mode pour les infirmières? La voici, Mlle Janet Geister nous dit: "Que l'infirmière en général réalise le besoin d'organisation, elle se demande ce qu'une organisation peut faire et doit faire. Son sens critique est plus aigu et elle s'adresse aux dirigeants, leur demandant de préparer un programme compréhensif, en n'oubliant pas les deux facteurs suivants intimement liés, inséparables: *Assurer des bons soins aux malades en prenant bien soin des intérêts de l'infirmière.*"

Elle ajoute: Aujourd'hui faire partie d'un comité celà veut dire—exercer un certain pouvoir et c'est à l'exercice de ce pouvoir que l'on juge le caractère. Accepter d'être sur un comité. Ce n'est pas tout simplement vouloir aider—il s'agit de se qualifier afin de faire le travail. Les infirmières savent que des intérêts de la plus grande importance sont actuellement en jeu. Elles réalisent que ces intérêts sont entre les mains des représentantes qu'elles ont élues et elles les regardent d'une façon critique et, oui, quelquefois d'une façon injuste.

Les infirmières, qui se chargent de diriger la profession ou aspirent à le faire, doivent s'attendre à y rencontrer de l'amertume autant que du plaisir. N'est-ce pas la part qui revient normalement à ceux qui éprouvent une satisfaction à rendre service dans la plus utile des professions?

L'Education du Personnel en Service

La fréquence du changement du personnel, aussi bien que sa rareté dans les hôpitaux et dans les services de santé, a préconisé l'adoption d'un programme permettant la formation du personnel lorsqu'il est en service.

Dans le numéro de mars de *Public Health Nursing*, l'on trouve une série d'articles concernant la formation du personnel. Les principes et les méthodes donnés concernant surtout les infirmières hygiénistes, mais ils pourraient facilement s'appliquer dans les hôpitaux avec quelques changements. Les trois facteurs suivant sont considérés dans l'énoncé des principes à la base de l'éducation du personnel: (1) L'éducation du personnel est un moyen permettant à l'organisation d'atteindre son but. (2) L'éducation du personnel est préparé pour des adultes participant tous à un même travail bien que le niveau de leur développement professionnel puisse être différent. (3) L'éducation du personnel n'est qu'une partie de l'éducation générale.

Dans un autre article de la revue consacré à la surveillance et l'orientation, l'on développe le principe suivant: La personne qui enseigne un travail à une nouvelle infirmière doit avoir

non seulement accompli la tâche qu'elle veut enseigner, mais elle doit être en mesure de l'évaluer. L'on insiste aussi sur l'orientation personnelle qui peut être faite lors de conférences de groupe, en exposant les problèmes particuliers de tel ou tel malade, la nécessité aussi de développer l'habilité, à s'entendre entre les membres d'un personnel toutes les occasions pour atteindre ce but—conférence, entretien, articles, revues devraient être utilisés.

L'article se termine ainsi: L'adage aide toi, toi-même, n'est pas un proverbe à citer mais un programme à réaliser. L'infirmière doit, à l'aide de l'enseignement reçu, apprendre davantage par elle-même et, sous la conduite de son professeur, elle doit être prête à accepter de nouvelles responsabilités dès qu'elle est en mesure de le faire.

On y trouve encore un autre article—"L'Enseignement Visuel"—puis un second—"La Formation en Service"—et finalement "Comment Développer l'Habilité dans le Soin Donné aux Malades." Dans cet article, on discute la valeur des tests d'habilité, de l'exécution du programme, de l'évaluation et des recommandations à faire.

Hospitalisation à Long Terme

Si les malades souffrant de maladies chroniques vous intéressent, lisez l'article publié dans *The Canadian Hospital* d'avril de Mlle Edna Nicholson (page 33). Le problème des cas chroniques y est clairement exposé et avec sympathie. La solution suggérée de ce problème comporte trois points: (1) Prévention; (2) contrôle et prévention d'une plus grande invalidité que celle déjà établie et moyens pour assurer à tous les malades chroniques, qui en ont besoin, les traitements permettant leur réadaptation; (3) que les soins donnés à ces malades, curables ou incurables, par les institutions ou par les agences diverses soient de première qualité.

Les difficultés à surmonter pour atteindre ces buts sont énumérés et l'auteur insiste sur la nécessité d'avoir un plan bien défini sur la formation professionnelle, etc.

Mlle Nicholson dit: "Le diagnostic et les soins à donner aux malades chroniques nécessitent les mêmes services que ceux que l'on donne aux malades ordinaires." Elle se demande s'il est désirable de diviser les hôpitaux pour malades ordinaires et pour malades chroniques. N'est-ce pas là une multiplication des services et du personnel et elle répète la recommandation si pressante du Dr. Bluestone et d'autres personnes, qu'il faut cesser de considérer les malades comme cas aigus et comme cas chroniques et, au contraire, qu'il faut reconnaître l'hôpital général comme un centre, ayant des services spécialisés et où toutes les catégories de malades peuvent y recevoir les traitements que requiert leur état. Elle termine son article en faisant un appel pour un meilleur usage des lits d'hôpitaux et pour que la société organise d'une façon intelligente le service des malades sans oublier la compréhension et la sympathie dont ont toujours besoin les pauvres humains.

Nouveautés Pedagogiques

Le Bureau des Actualités de Londres, en Angleterre, donne un cours nouveau sur les Méthodes de Discussion. Deux infirmières, qui ont suivi le cours avec des représentantes de l'armée, d'université, de l'industrie, etc., rapportent leur expérience dans le *Nursing Times* du 16 avril (page 306).

Le Bureau des Actualités (Bureau of Current Affairs) est indépendant, éducatif, sans but lucratif et libre de toutes attaches politiques, était organisé en 1946 par l'Institut Carnegie du Royaume Uni, lequel croyait que "la démocratie repose sur la discussion et qu'une discussion ayant réellement de la valeur repose sur la connaissance des faits."

Le cours est donné à de petits groupes, pas plus de douze personnes à la fois, et chacun participe aux cours, ce qui lui permet de mettre en pratique l'enseignement reçu. Dans toutes bonnes discussions, trois facteurs sont nécessaires: (1) Maintenir l'intérêt; (2) le chef de groupe doit avoir tous les renseignements nécessaires à la portée de la main; et (3) le contrôle du groupe est très important pour avoir de bonne discussion. Ce cours fut vivement apprécié par les infirmières et elles se demandent si tels cours ne pourraient être organisés pour nos institutrices, les hospitalières, etc.

Aide Pécuniaire

Voici un extrait d'un rapport publié par le Ministère du Travail pour l'année budgétaire de mars 1948: "L'entente de l'Aide à la Jeunesse, laquelle permettait de venir en aide à tous les étudiants, est de nouveau entré en vigueur dans toutes les provinces. C'est l'aide la plus en demande. Les élèves-infirmières dans nos hôpitaux sont éligibles de même que les infirmières poursuivant leur cours dans les universités. Les candidates aux bourses doivent démontrer qu'elles ont

du succès et qu'elles sont incapables, faute d'argent, de continuer leurs études. Chaque province décide si l'aide donnée doit être considérée comme un prêt ou une bourse. Cette aide permet à beaucoup de jeunes filles de suivre le cours d'infirmière; celles qui désiraient devenir infirmières, et qui n'avaient pas d'argent, peuvent maintenant le devenir."

Annual Meeting in Manitoba

The thirty-fifth annual meeting of the Manitoba Association of Registered Nurses was held April 19-20, in the Fort Garry Hotel, Winnipeg. Two hundred and twelve members registered. Two afternoon sessions and two evening sessions were held.

Miss Mildred McMurray, legal consultant, provincial Department of Health and Welfare, addressed the dinner session, the title of her address being "Your Profession and Mine." Her remarks stirred the thoughts of all present to the responsibilities of professional people in a democratic society.

An honorary membership was presented to Mrs. W. J. Harrington (Agnes Isabella Laidlaw) of Dauphin, Man., and a 1907 graduate of the Winnipeg General Hospital School of Nursing. Mrs. Harrington has been an active member of the M.A.R.N. ever since its organization in 1913, being Registrant No. 20. She is an enthusiastic member of the Dauphin Graduate Nurses Association of which she is a past president. In addition to her nursing interests, Mrs. Harrington has taken an active part as a citizen of the community in which she lived.

Mrs. Garnet Coulter, wife of the mayor of Winnipeg, addressed the luncheon meeting, emphasizing to the group the obligations of women as citizens.

An excellent panel discussion on "The Influence of Psychiatric Treatment and Practice upon Nursing" was presented by Dr. George Little, Dr. Gordon Stephens, and Miss Caroline Wedderburn.

Miss Helen L. Wilson, matron, Deer Lodge Hospital, was elected president, succeeding Miss Irene M. Barton.

The meeting unanimously approved of the following amendments to the Constitution and By-laws:

1. That the annual re-registration and membership fee for the Manitoba Association of Registered Nurses be increased from five dollars, as at present, to eight dollars for active practising members, commencing January 1, 1950.

2. That an annual re-registration and membership fee of four dollars be established for active non-practising members, commencing January 1, 1950.

3. That an active practising member who permits membership to lapse at March 31, of a given year, may be reinstated between April 1 and December 31 of that same year by payment of the fee for the current year plus a reinstatement fee of two dollars; and that an active practising member, who permits membership to lapse for one year or more, may be reinstated by payment of the fee for the current year plus a reinstatement fee of seven dollars.

4. That an active non-practising member who permits membership to lapse may be reinstated at any time as an active non-practising member by payment of the current year's fee therefor.

LILLIAN E. PETTIGREW
Executive Secretary

Bi-focals

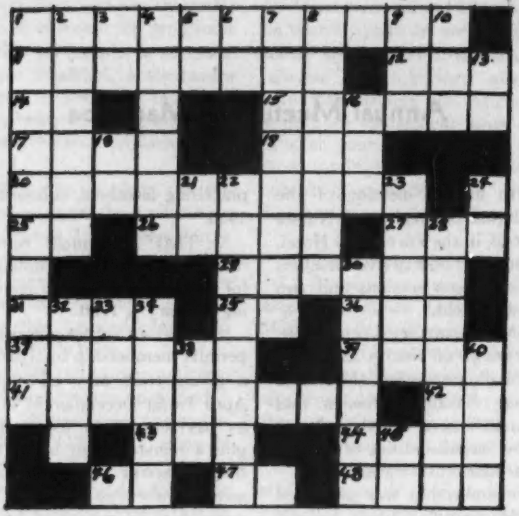
The world is indebted to Benjamin Franklin for the invention of bi-focal lenses.

It was in 1784, while Franklin was ambassador to France, that he developed this important optometric discovery. The 78-year-old sage always wore glasses and he could not, without them, "distinguish a letter even of large print." But the story is best told in his own words:

"Before that year I had used two pair of spectacles which I shifted occasionally, as in travelling I sometimes read and often wanted to regard the scenery. Finding this change troublesome and not always sufficiently ready, I had the glasses cut and half of each kind (of lens) associated in the same circle."

Thus one pair of glasses automatically corrected near- and far-sightedness.

Crossword Puzzle Page



ACROSS

1. Ambulatory dandruff.
11. Everted.
12. Meadow.
14. A short junior officer.
15. The red lane.
17. Will cause a current of one amp. to flow against a resistance of one ohm.
19. A tonic—if ordered.
20. Absorbing 19 across.
25. A possessive personal.
26. Halves Latin.
27. A sweet potato.
29. Ability to get going.
31. Small pipe.
35. Abbreviated United Nations.
36. Or's friend.
37. Spinal depressant and miotic.
39. If winter comes, comes—.
41. Fat folk are this.
42. Double prefix.
43. This can carry germs, too.
44. A backward fibber.
46. What Clara Bow had.
47. You Old English you.
48. Members of 35 across need it.

DOWN

1. An obstetrician's measurer.
2. Cutting it out.
3. Brief spell of pink elephants.
4. A pain in the I.
5. Put it in care of.
6. How high is.
7. A tie business.
8. He looks deep in your eyes.
9. Sick.
10. I'll be able to after 8 down is through.
13. Preposition.
16. Lyin'.
18. Hard for 14 across to lose one.
21. A bee that lost its tail.
22. Desirable state regarding infections.
23. Wearing longest hose.
24. Nurses rise in the early—.
28. Needs plenty of oxygen.
30. Slip in almost unnoticed.
32. This is not new.
33. Nurses hate to leave it.
34. Break out in odd places.
38. Co-o-old!
40. Me and flowers do this if nobody cares.
45. Of each to the druggist.

(*Solution on page 542*)

Student Nurses

Meningococcic Meningitis

MARGARET FULLERTON

Average reading time — 15 min. 12 sec.

EXPLANATION OF DIAGNOSIS

MENINGITIS is an inflammation of the meninges or membranes covering the brain and spinal cord, resulting in the formation of pus in the spinal fluid. Although the disease may be caused by a variety of organisms, including streptococci, staphylococci, pneumococci or tubercle bacilli, 75 per cent of the cases of meningitis are caused by meningococci. *Neisseria intracellularis*, commonly called the meningococcus, causes epidemic meningitis, the only form of the disease which is contagious.

The meningococcus invades the body through the nasopharynx, frequently causing a local inflammation of this area. The bacteria then enter the blood stream, in some cases persisting in the blood and giving rise to local infections in other areas as well as in the meninges, but usually disappearing from the blood soon after the onset of meningitis. The untreated disease has a high mortality rate.

Meningococcic meningitis is an endemic disease, occurring sporadically in cities almost every winter. It may flare to epidemic proportions in widely separated areas, being spread largely by carriers who harbor the organisms in their throats and spread the disease by direct contact through droplet infection, or by indirect contact with articles freshly soiled with discharges from the nose and throat. Overcrowding is usually considered particularly important in facilitating the spread of meningitis.

The meningococcus, like the pneumococcus, occurs as a series of types distinguishable by agglutination tests. Typing was important formerly when serum therapy was the only treatment, but now the sulfa drugs and penicillin have proved more effective and no typing is required.

Miss Fullerton was a student at the Vancouver General Hospital when this study was made.

HISTORY

Betty, a two-year-old child, was well until the evening of October 17 when she appeared listless and slightly feverish. The next morning her temperature was 100.8° rectally. Nausea, vomiting, and constipation were present, but there was no neck rigidity. A faint pink, macular, non-petechial rash was evident in scattered clumps over her body. By October 19, she had become increasingly apathetic, vomited all food taken, and her temperature rose to 102° rectally. Examination on that day showed definite neck rigidity and a positive Kernig's sign on the right side. There was definite opisthotonos and listlessness almost to the point of coma. A fine petechial rash was in evidence over her entire body, including the conjunctiva.

Betty was admitted to the Infectious Disease Hospital on October 19, conscious but very listless, with a stiff neck and marked opisthotonos. She endeavored to assume a characteristic position, lying on her abdomen with knees drawn up, her head turned to one side and retracted. A fine petechial rash still covered the entire body. Her face was flushed, she was restless, and was crying almost constantly—the high-pitched baby-like cerebral cry. Her temperature was 102.4°, her pulse was unobtainable due to restlessness, her respirations were 44 per min.

Significance of Physical Findings

The stiffness of the neck is due to an effort on the part of the body to splint the injured meninges while the position of opisthotonos appears to be the most comfortable that the patient can assume. The symptoms of toxicity are caused by an endotoxin released from the meningococci when they disintegrate. The rate and quality of the pulse offer a good indication of the degree of intoxication present. The typical cerebral cry is uttered when the tissues of the cerebrum are being injured in the course of a disease. The appearance of a petechial rash is always a grave sign, and is caused by damage to the capillary walls by the liberated toxins.

Laboratory Findings

Spinal fluid

1. *White cell count:* Oct. 19—4,860 per cu.mm. of spinal fluid; Oct. 20—5,280 per cu.mm. of spinal fluid; Oct. 27—8 per cu.mm. of spinal fluid.
2. *Differential white cell count:* Markedly increased polymorphonuclear leukocyte count.

   White blood cells, particularly polymorphonuclear leukocytes, migrate from the blood into the cerebrospinal fluid to combat the meningococci. The fluid is cloudy due to the presence of the phagocytes and meningococci, and is under increased pressure since additional fluid is secreted in response to the irritation of the meninges.
3. *Sulfadiazine level:* Oct. 20—10 mgm. per 100 cc. spinal fluid.

   It is necessary to know the amount of the drug which is actually contacting the meningococci and to have an accurate knowledge of the amount of sulfadiazine retained in the body since a severe reaction to any sulfa drug is not uncommon.
4. *Culture:* Oct. 19—Gram negative diplococci resembling meningococci present in the culture; Oct. 20—No definite organisms present in the smear. No growth in the culture in 10, 14 or 38 hours.

   A positive smear demonstrates the organisms as pairs of gram-negative, bean-shaped organisms often held within the phagocytes, hence the name intracellularis. A large number of free organisms is an unfavorable sign since it suggests an inability of the phagocytes to combat the organisms. The meningococci appear to have been killed rapidly from the combined effects of the treatments given.
5. *Sugar content:* The sugar content of the spinal fluid is greatly reduced or absent.

Blood

1. *Morphology:* Oct. 19—8,900 leukocytes per cu.mm. of blood; Oct. 23—10,300 leukocytes per cu.mm. of blood.

   These figures give evidence of a slight leukocytosis.
2. *Sulfadiazine level:* Oct. 20 (early)—13 mgm. sulfadiazine per 100 cc. blood; Oct. 20 (later)—20 mgm. sulfadiazine per 100 cc. blood; Oct. 22—20 mgm. sulfadiazine per 100 cc. blood.
3. *Culture:* Oct. 19—no growth in 36 hours.

   The organisms usually disappear from the blood rapidly after the onset of meningitis.

Urinalysis:

Oct. 20—Acetone + 4, sugar + 4.

This result is due to dehydration caused by vomiting and inability to eat. The decreased glucose supply to the body results in the formation of acetone bodies. Otherwise, the urinalysis was normal.

Routine nose and throat swabs

Oct. 23—negative for diphtheria.

Medications

Penicillin

(a) 50,000 units intrathecally on admission; given as the most direct and rapid method of combatting the meningococci. Spinal fluid was withdrawn first for diagnostic purposes.

(b) 50,000 units intramuscularly on admission.

(c) 25,000 units I.M. q.3.h. until Oct. 22.

(d) 25,000 units I.M. q.6.h. until Oct. 24.

Penicillin has a definite antibacterial effect on meningococci and has few toxic effects.

Sulfadiazine

(a) 2 cc. in 8 cc. distilled water in each gluteal muscle on admission.

(b) Gr. xxii with soda bicarbonate gr. x

in orange juice on admission but not retained.

(c) 5 cc. into I.V. tubing at 10:45 p.m. and 2 cc. at 4:00 a.m.

(d) Gr. xv with soda bicarbonate gr. x per Levine tube at 1:00 p.m.

(e) Gr. viiss with soda bicarbonate gr. v. q.4.h. per Levine tube until Oct. 21 when the tube was removed and the medication continued orally until Oct. 24. Then the dosage was reduced to q.6.h., and continued until the patient was discharged.

Sulfadiazine effectively combats the meningococci, but it may cause a severe reaction. The nurse must be on the alert for scanty urine or a rash. A daily urinalysis is advisable to check on crystal formation as the sharp crystals sometimes formed are very injurious to the kidneys. Fluids are forced to rid the kidney of formed crystals mechanically, and soda bicarbonate is given with the drug to make the urine alkaline and inhibit crystal formation. A blood examination should be done every few days in case anemia or leukopenia develop.

Sedatives

1. Seconal gr. i rectally at 10:45 p.m. Oct. 19. This is a barbiturate derivative used as a sedative for nervousness and restlessness and to produce sleep. It is a comparatively safe drug in small doses.

2. Sodium luminal gr. ¼ "H" at 2, 5 and 8:00 a.m. on Oct. 20. Sodium luminal gr. ½ "H" at 10:00 a.m.

Sodium luminal is also a barbiturate. The barbiturates lessen nervous irritability and produce sleep by preventing afferent impulses from reaching the brain. They lower metabolism, the temperature, and the blood pressure.

Betty was extremely restless, turning and twisting continuously. The sedatives quietened her for short periods only.

3. Phenobarbital gr. ½ at 7:00 p.m. for restlessness. By this time the child was becoming less restless and more responsive. She required very little sedation during the remainder of her stay in hospital.

Treatments

Spinal puncture on admission. This puncture was performed for diagnostic purposes and to inject penicillin as the most direct means of combatting organisms. Spinal puncture twenty-four hours later was performed to determine the concentration of sulfadiazine in the spinal fluid, and to discover whether or not the organisms were still present. No organisms were discovered by smear or culture. The spinal puncture on the day preceding discharge revealed that the fluid was clear with a cell count of 8 per cu. mm. of fluid.

An *intravenous* of 5% glucose in distilled water was started on the night of admission. The fluid was necessary to restore the dehydrated tissues to normal, and the glucose to supply nourishment and to allow the acetone bodies to be broken down completely. In spite of restraints, the child's extreme restlessness forced the needle out of the vein and, after unsuccessful attempts to make use of other veins, a cut-down had to be resorted to. The I.V. stopped running at 8:30 a.m. and was discontinued, 1000 cc. glucose in distilled water having been given.

A *Levine tube* was inserted at 10:00 a.m., Oct. 20, to enable sulfadiazine and fluids to be given. Two ounces of water were given every half-hour, and on the following day three ounces of milk every four hours were added.

An *S.S. enema* on Oct. 22 was given with good results. Frequently in meningitis there is retention of urine and feces. Betty had involuntary micturitions during the acute stage of her illness but constipation was present.

Nursing Care

In former times when meningitis was a prolonged disease, the recovery of the patient depended largely on the quality of the nursing care he received. Now, with advanced treatments, the transition from the practically comatose stage to apparent recovery takes place within a few days. The nursing care during the acute stage remains of great importance, but the nurse does not deal with a patient who has suffered over a long period of time. All nursing procedures are carried out under isolation precautions. A daily bed bath

and frequent alcohol rubs to bring down the temperature are advisable.

During Betty's acute stage, the main nursing care, apart from medications and treatments, was to quieten her, endeavor to keep the intravenous needle in place, the bed-clothes over her to prevent chilling, and to keep her from removing the Levine tube. Care to the mouth, nose and ears could not be given while her restlessness persisted.

Meningitis patients are very sensitive to external stimulation; therefore the patient should be in a quiet room. Bright lights and any jarring of the bed should be avoided. There is a generalized hyperesthesia of the skin. Betty was constantly attempting to rid herself of the bed-clothes. Bed-cradles could be used to alleviate this situation.

The fluid intake and output should be measured, especially when sulfa drugs are being administered as a decreased urine output or even anuria may occur. Fluids should be forced and high caloric alkaline fluids given until solid foods are tolerated. By the evening of Oct. 21 Betty was hungry and took her supper well. The following day she was playing in her crib and was discharged on Oct. 28 apparently well, no complications.

Possible Complications

These include: secondary infections such as pneumonia, otitis media, conjunctivitis, arthritis, cystitis, or endocarditis. Hydrocephalus is the most important complication, and is due to the exudate or adhesions blocking off one or more of the various foramina and causing an accumulation of fluid within the ventricles. In very young children, the increased pressure of the spinal fluid may force the structures of the anterior fontanel to bulge outwards. Weakness of the facial muscles is sometimes present and weakness or paralysis of the eye muscles may result in strabismus or diplopia. Impaired hearing or even deafness may occur if the eighth cranial nerve is injured.

Health Teaching

Since any factor which lowers the resistance of the nasopharyngeal mucous membrane, such as abrasions or congestion, will favor the entrance of the organisms, the avoidance of colds is of primary importance. Overcrowded conditions, such as are found in barracks or slums, offer excellent opportunity for meningococcal infections. Vaccines are available but their use is not widespread because many people are already immune from small doses of meningococci encountered during their normal activities. Many of these people are carriers. It is those persons, coming from thinly populated areas and suddenly encountering crowded conditions, who most frequently develop the disease.

This case was one of the most interesting that I have witnessed since it demonstrated a spectacular victory of modern medical science over a disease which has brought death and mental deterioration for centuries. Now the span from illness to recovery can be accomplished in one week.

Book Reviews

A.N.A. Public Relations Workshop—A manual of practical public relations techniques prepared for the guidance of the national membership of the American Nurses' Association. 32 pages. Published by American Nurses' Association, Inc., 1790 Broadway, New York City 19. (A limited number of copies may be obtained from the Canadian Nurses' Association, 1411 Crescent St., Montreal 25.—Price $2.50.)

Reviewed by Marion E. Nash, Assistant Secretary, Canadian Nurses' Association.

The introduction by Ella Best, executive secretary, American Nurses' Association, outlines the background of the workshop, stating the purpose of the project to be an attempt to help the American Nurses' Association membership learn *how* to reach their public and what technique to use in the process. A portable workshop, from which the A.N.A. Public Relations workshop is adapted, was decided upon as the best means of reaching the greatest number of members and Mr. Edward L. Bernays, the A.N.A.'s counsel on public relations and an outstanding leader in this field, was commissioned to prepare a series of talks on public relations and publicity techniques. The workshop discussions, printed in this manual and intended to demonstrate to nurses how public relations techniques can be mastered and applied, deal first with basic principles and, second, with tools and techniques.

In the first chapter, Mr. Bernays defines the words "public relations" and "public"; indicates how information is secured; establishes the principle "that public relations activities should be based on knowledge, on evidence, on an understanding of the areas of maladjustment between a group and the public at large"; reviews the six planks of the A.N.A. platform and outlines an introductory course on the principles, policies, and practices of public relations as developed over the past twenty-five years.

His later chapters deal with methods and tools under the following headings: the press; news and its meaning; the radio; the movies and television; the written and spoken word; visibility; and closes with "what you need to know about your community and why, if you expect to fit your objectives into the community pattern." He makes the following statement: "You cannot change the public's attitude or form its opinions until *you have taken its measure.* Your study of the climate of public opinion will determine how to approach the public in your community. You must know what activities are likely to succeed—what appeals are most likely to be effective and what strategies have the best chance of succeeding. The citizens of your community can be educated to identify their own interests with the best interests of nursing . . . Making the community study we have recommended will help define your own public relations program and assist you in gaining public support."

This manual is authoritative, brief, well illustrated. The chapter headings are short and catchy. It contains answers to many of the questions the nursing profession has been asking on public relations. It should be a very valuable aid to anyone interested in improving relations between the Canadian nurse and her public.

Introduction to Chemistry, by Bertha S. Dodge, A.B., M.S. 312 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1948. Illustrated. Price $3.85.

Reviewed by Sister M. Melanie, Instructor of Nurses, St. Mary's Hospital, Montreal.

Because of the great number of recent changes in the development of the field of chemistry, the author has recognized a need for a complete revision of our approach to the subject and has successfully endeavored to carry out such a revision.

The author has had considerable experience in teaching chemistry to student nurses and this has been of great value to her in making a careful choice of material on the basis of the needs of the nurse, and the limited time usually at the disposal of teachers of this subject in schools of nursing. Chapter 2, which deals with the fundamental concepts necessary for the foundation of chemistry, is clearly and concisely set forth. Chapter 5, which deals with oxygen and carbon dioxide in their relation to the human body, and Chapter 10, which clearly explains the fate of foodstuffs in the body, are particularly well adapted to the requirements of the nurse and should be of much value to her in the understanding of physiology and nutrition.

The bold face type headings of each paragraph make a quick survey of material easy. The summaries of the important definitions and the problems for study outlined at the conclusion of each chapter will serve as a valuable review for the student. The good quality paper and the clear print make the book easy and pleasant reading.

The teacher of chemistry in the school of nursing will find a valuable tool in this book, either as a handy reference book or as a text for students.

Laboratory Manual Introduction to Chemistry, by Bertha S. Dodge, A.B., M.S. 103 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St.,

Toronto 1. 1948. Illustrated. Price $3.00.
Reviewed by Sister M. Melanie, Instructor of Nurses, St. Mary's Hospital, Montreal.

The laboratory assignments are placed at the end of each chapter in the textbook and the experiments in the manual are well correlated with the material in the text. The experiments have been carefully chosen as an aid in the understanding of the subject matter. Here we find a wealth of valuable material, but I believe most of our hospital schools of nursing would be hard pressed for sufficient time to use them to the best advantage.

The perforated work-sheets are an excellent feature, both as time-savers and as an aid to the student in the accomplishment of the desired results.

Polio and Its Problems, by Roland H. Berg. 174 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1948. Illustrated. Price $3.75.
Reviewed by Dorothy M. Hopkins, Provincial Normal School, Saskatchewan Department of Education.

"Polio and Its Problems" is a partial record of research in the United States, to date, into the cause and control of the disease which stalks its prey, most frequently, in "the good old summertime" and, coincidentally, with the coming on the market of "sub-tropical fruits."

While the book is not worded in the imagery of de Kruif, it is, nonetheless, a detailed, painstaking effort to inform the public of the difficulties inherent to research of finding a vaccine that will be innocuous to those vaccinated, as well as a preventive of the disease.

The laity to date has been much impressed by the Kenny concept, an opinion aided by the film of that name. Several advances in the treatment of polio must be credited, by persons of open minds. These include: (a) a lessening of crippling (permanent) in children; (b) the avoidance of the use of mechanical appliances; (c) the adoption of muscle re-education. The text does not condemn the treatment as unorthodox, realizing that science cannot afford to be stifled by too rigid adherence to what passes for orthodoxy.

Apparently, the disease is more virulent in some sections of this continent than in others —"*Polio is yet an uncontrolled disease.*" Consequently any book that will assist in securing that control is to be commended, despite the fact it may not allay the fears of the laity or prevent panic during an epidemic.

The difficulty in finding experimental material is stressed and, in view of the similarity of a brain disease in horses—namely, encephalomyelitis—communicable to humans, cheap equines might be used. For the record it may be stated the disease in horses occurs usually in "fly time" and is preventable by a vaccine. The differential diagnosis between the two diseases in humans has been effectively worked out by the pathologist (Fulton) of the University of Saskatchewan.

Laboratory Chemistry for Students of Nursing, by Eleanor M. K. Darby, Ph.D. 101 pages. Published by G. P. Putnam's Sons, New York. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1948. Illustrated. Price $2.50.
Reviewed by Henrietta J. Alderson, Lecturer in Nursing, McMaster University, Hamilton.

This manual, arranged in twelve two-hour laboratory exercises, is intended to complement a lecture and classroom schedule of twenty-four hours. All types of chemical reaction—inorganic, organic, and biochemical —are included though no special reference is made to experiments in chemical digestion and those related to organic reactions are limited.

The periods devoted to the metric system of measurement, the characteristic properties of solutions and their diffusibility through membranes, the action of detergents and water softeners, and the chemical principles underlying effective stain removal would afford excellent opportunity for integration with the introductory studies in pharmacology, anatomy and physiology, and nursing arts. Included among others is an exercise demonstrating titration of acids and bases and the amphoteric nature of proteins. An excellent outline for routine analysis of urine completes the series.

The manual, the usual loose-leaf type, provides space for observations and answers to questions. Beginning with general instructions for the guidance of the student in the laboratory, it closes with helpful suggestions for the instructor in preparation for each period. This manual would prove helpful to any instructor outlining a forty-eight hour lecture and laboratory course and could be used as the nucleus for more extensive work, time permitting.

As soon as you feel too old to do a thing, do it.

Alberta Public Health Nursing Service

M. E. Hagerman, of the Child Welfare Clinic, Medicine Hat, has taken leave of absence to attend the I.C.N. Conference in Stockholm. She will also visit Britain and the Continent. *Emily Mayhew*, formerly with the V.O.N. in Ottawa, is relieving in Miss Hagerman's absence. *Enid Doyle*, of Maloy, has been called to mission work which will eventually take her to India.

New additions to the staff include *Kay Willis, B.Sc.*, stationed at New Brigden, and *Marie T. Lefebvre*, recently graduated from Misericordia Hospital, Edmonton, who is at Valleyview. *M. L. White* has been transferred from Worsley to Whitecourt. *Mrs. K. P. Cole* has resigned to become matron of Mayerthorpe Hospital and *Frances Smith*, New Brigden, has left to be married.

Laura Attrux has returned from a special course in Kentucky and New York and is now in Smith district, replacing Miss *Nordtorp* who is on leave of absence. *Ethel Jones*, of Bow Island, has moved into another cottage, a great improvement over the old one, and now has electric lights, running water, and gas for cooking.

Canadian Red Cross

The following are staff changes in the Provincial Divisions of the Canadian Red Cross Society:

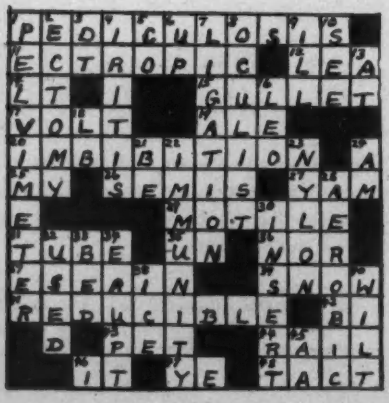
Ontario: APPOINTMENTS — *Oda Hansen* (Toronto General Hospital) to Red Lake; *Helen McCue* and *Joan Boyce* (St. Joseph's Hospital, Toronto) to Thessalon; *Anna Purvis* (Wellesley Hospital, Toronto), *Doreen Thomas* (St. Paul's Hospital, Vancouver), and *Ruth Woollaat* (T.G.H.) to Dryden; *Peggy Parker* (Wellesley Hospital, Toronto) to Emo; *Doris Scott* (St. J.H., Toronto) to Rainy River; *Margaret Guidera* (St. Mary Abbotts Hospital, London) to Bancroft; *Isabel McCormick* (Port Arthur General Hospital) to Atikokan; *Mildred Harten* (Plummer Memorial Hospital, Sault Ste. Marie) to Nipigon; *Beth Kirkpatrick* to Huntsville.

TRANSFERS—*Margaret Peart* from Emo to Beardmore; *Donna Thompson* from Mindemoya to Hawk Junction; *Elizabeth Mangelson* from New Liskeard to Hornepayne; *Pearl Merriam* from Port Loring to Kakabeka Falls; *Marjory Rilett* from Atikokan to Port Loring; *Anne Vasilovich* from Hawk Junction to Hornepayne; *Rae Young* from Rainy River to Red Lake.

RESIGNATIONS—*Madeline Armour* from Bancroft; *Bernice Byford* and *June Coles* from Hornepayne; *Margaret Bulger* from Englehart; *Estelle Cahill* from Thessalon; *Barbara Cox* from Kakabeka Falls; *Elsie Jenner* from Beardmore to be married; *Elaine Read* from Mindemoya; *Donna Thompson* from Hawk Junction; *Janie MacEwen* from Red Lake.

Quebec: APPOINTMENTS — *Pierrette Marchand* (St. Eusèbe Hospital) and *Mary Ford* (Montreal General Hospital) to Barachois, Gaspé, the latter replacing *Lillian Liddle* who resigned.

Saskatchewan: APPOINTMENTS—*K. Cowell* (Victoria Hospital, Prince Albert) to Hudson Bay; *Irene Adolph* (Holy Family Hospital, Prince Albert) to Loon Lake. TRANSFER—*I. Turnbull* from Hudson Bay to Big River. RESIGNATIONS—*Lois Stav* from Loon Lake; *Florence Lambsdown* from Arborfield.



Ontario

The following are staff changes in the Ontario Public Health Nursing Service:

Appointments: *Pearl Stiver* (Toronto Western Hospital; University of Toronto certificate course; B.S., Teachers College, Columbia University), formerly consultant in nursing, Division of V.D. Control, and regional supervisor, Division of Public Health Nursing, Ontario Department of Health, as director, public health nursing, Ottawa Department of Health; *Elaine Read* (U. of T. diploma

course) North York Board of Health; *Muriel (Hunter) Heimbecker* (Toronto General Hospital and U. of T. cert. course) Waterloo Board of Education.

Resignations: *Patricia (Bourke) O'Donnell* (St. Joseph's Hospital, London, and University of Western Ont. cert. course) from Kirkland-Larder Lake health unit.

Nursing Sisters' Association

At the annual meeting of the *Halifax Unit* the following officers were elected: President, Agnes Butler; vice-president, Rose King, R.R.C.; secretary, Georgina Thompson; treasurer, Blanche Dill; program convener, Marion Haliburton; visiting committee, Kate Graham, Marjorie McGlashan. The past president is Jean Nelson, R.R.C.

News Notes

ALBERTA

EDMONTON:

Royal Alexandra Hospital:

At a recent meeting of the alumnae association, it was reported that food parcels were being sent to two British nurses. The guest speaker was Dr. Hal Richard, whose talk on "Cancer" proved interesting.

RED DEER:

Velma Hall, superintendent of the Innisfail Municipal Hospital for the past six years, and a member of the staff for sixteen, has resigned.

BRITISH COLUMBIA

ABBOTSFORD:

Seventeen members and one visitor were present at a regular meeting of Matsqui-Sumas-Abbotsford Chapter when Miss Towlan gave an account of the R.N.A.B.C. annual convention. The treasurer's report showed a bank balance of $167.76. It was decided that $100 of the chapter funds should be set aside to enable a graduate of the local high school to enter a school of nursing, and that the public health nurses should confer with the high school teachers to choose the most deserving applicant.

CHILLIWACK:

Dr. Digby Leigh, chief anesthetist at the Vancouver General Hospital, was guest speaker at a meeting of Chilliwack Chapter. He gave an instructive lecture on the administration of anesthetics. Dr. Enns assisted in the showing of the slides.

A hand-made rug and a doll's crib were displayed as prizes for the summer tea. During Nurses' Week a store window was decorated, showing diplomas, caps, and pins of the various schools across Canada as well as three mannequins in complete uniform. It was reported that around thirty members attended St. John's Anglican Church in Sardis for the National Nurses' Memorial Service. K. Crowley commented on the Recreation Centre meeting while Mrs. Roberts welcomed new and old members.

KAMLOOPS:

Hazel MacInnes, who resigned as superintendent of nurses at Royal Inland Hospital, was honored at a tea given by the nursing staff. Assisting were R. Harrison, Mmes C. B. Corbould, E. H. McKenzie, and J. L. Gordon.

NELSON:

A graduate of Kootenay Lake General Hospital and latterly assistant superintendent, Vera Hayden has been appointed to a similar post at MacDougall Hospital, Kimberley. During her fourteen years' service on the staff, Miss Hayden held many positions, including that of acting superintendent.

PRINCE RUPERT:

Mary Morton, who has been for some time assistant lady superintendent at Miller Bay Hospital, is now on the hospital staff at Prince Albert.

VANCOUVER:

Each spring the Public Health Committee, R.N.A.B.C., holds its annual party. This year, Alice Beattie, chairman, asked Queenie Donaldson, of the Metropolitan Health Committee, to act as convener.

"The Hollies," a stately and beautifully appointed house in Old Shaughnessy, provided a gracious setting. After a buffet supper, Miss McRae, of the Vancouver Art School, gave a talk on "Pottery and Other Handicrafts," following which the Hobby Show was opened. On display were: Leatherwork, painting, pottery, photography, weaving, collections of fine linens, knitting, crotcheting, etc. Evidence was shown of the public health nurses' appreciation of the part hobbies play in making a well-balanced life. Posters served to illustrate some of the hobbies not otherwise demonstrable.

The party ended on a gay note with the performance of square dances by nurses who had attended classes. The evening proved stimulating to the 143 public health nurses present, and the three students who attended as special guests.

MANITOBA

BRANDON:

The Association of Graduate Nurses held their annual dinner and dance when the new graduates of the General and Mental hospitals were welcomed into the association. Each one was presented with a year's membership as a gift. The president, C. Wedderburn, proposed the toast to the King and absent members, while Mrs. E. Griffin made the toast to the new graduates to which G. Wolfe replied. O. Thomas, superintendent of nurses, General Hospital, congratulated the new members of the profession, impressing upon them the seriousness of their work.

Rev. Nelson Mercer was the guest speaker. He spoke of professional skill and interest in fellow humans and the deep sense of the worth of people, no matter what station in life they might have.

During the business meeting, Mrs. Hotson, Misses Markey and McCausland reported on the M.A.R.N. annual convention. N. Crighton gave the annual report and Mrs. P. Dick reported on the state of the finances of the group. L. Cook gave a vote of thanks to the retiring executive and M. Patterson expressed the appreciation of the members to R. Down and her committee for their dinner and dance arrangements.

The guests of honor included Mmes Purdie, Sr., J. Esslemont, N. Mercer, and Miss C. Macleod, the latter revealing that she was present at the first association meeting ever held.

Nineteen nurses graduated from the General Hospital recently, bringing the total number of graduates from that school since its establishment in 1890 to approximately seven hundred. Dr. J. A. Findlay presented the graduates, while J. C. Donaldson, president of the board of directors, conferred the diplomas. The superintendent of nurses, Olive Thomas, "pinned" the graduates. Scholarships were awarded as follows: John R. Brodie scholarship, 3rd year, Ora Watts; A. L. Kerr scholarship, 2nd year, Leona Paige; Mabel E. Harrison scholarship, 1st year, Wahnetah Elliott. Dr. Fjeldsted, assisted by Dr. Purdie and Miss Thomas, presented the medals and prizes as follows: Third year—Gold medal, G. Wolfe; silver medal, O. Watts; bronze medal, B. Grigg; eye, ear, nose and throat, G. Wolfe; psychiatry, J. Adams. Second year—Highest standing, also orthopedic, pediatric, and surgical nursing prizes, L. Paige; medical nursing, S. Strang; obstetrical nursing, D. Lewis. First year—Bedside nursing, J. Kenean. The I.O.D.E. bursary was won by Mary Ann McRae.

The "first lady of the province of Manitoba," Mrs. R. F. McWilliams, was the guest speaker when her theme was "Adventuring."

Entertainments for the new class included: Graduate class dance, weiner roast, and mother and daughter tea given by intermediate class; graduates entertained at the home of Jean Harding; buffet supper given by Mrs. S. J. Higgens; dinner and movie given by General Hospital staff.

Winnipeg General Hospital:

Mary Shepherd, superintendent of nurses, Municipal Hospitals, was re-elected president of the alumnae association at the annual meeting. The alumnae, formed in 1904, has more than 650 members. A highlight of the year for the association was the conferring of an honorary degree of Doctor of Laws on Ethel Johns by Mt. Allison University. The alumnae presented the cap and gown to Miss Johns.

From funds totalling $2,879, two scholarships were presented last year to students for post-graduate work at the University of Manitoba and Johns Hopkins University. A donation of $75 was made to Zenana Bible and Medical Mission to help with the training of a student nurse in a hospital in India. For the past twenty years, this sum has been donated by the alumnae. Films for student nurse training were purchased for the school of nursing. Copies of the alumnae journal, first published in 1907, have been sent to all members.

Assisting Miss Shepherd on the new executive are the following: Vice-presidents, Mrs. H. Lindford, G. Bedford, Mrs. M. Beamish; recording and corresponding secretaries, C. Torrie, D. Marshall; treasurer, Mrs. D. Christie. Additional members are: G. Hunter, A. Stevenson, M. Perfect, I. McDiarmid, L. MacDonald, Mmes R. Waldie, N. Norquay, B. Crawford, A. C. McFetridge, P. Swan, H. White.

Members of the Vancouver branch of the alumnae helped Sarita Pickens, an 1897 graduate, celebrate her 90th birthday on May 16. She was delighted with the gifts and flowers she received. Her many friends will be pleased to know that she is in good health and spirits.

NEW BRUNSWICK

MONCTON:

Fifteen nurses received their diplomas at the graduating exercises of the Moncton Hospital when Dr. Gass, of Sackville, was guest speaker. Orma Smith, superintendent of nurses, Saint John General Hospital, led the nurses in the Nightingale Pledge. Dr. P. Melanson, president, Moncton Medical Society, and B. Beattie, superintendent of nurses, Moncton Hospital, presented the class with their pins and diplomas.

Prizes were awarded as follows: B. Blakney, general proficiency; Mrs. O. Appleton, Dr. Ross prize for eye, ear, nose and throat; W. McMinn, Moncton Chapter prize for three years' highest standing in principles and practice of nursing; J. Byers, Senior Hospital Aid prize for obstetrical nursing; C. MacLeod and M. Dodge, Nurses' Hospital Aid —two $100 bursaries in obstetrical nursing; B. Blackney — head nurses' award to nurse contributing the most to her profession and keeping up morale of her class; J. Byers, Fort Moncton Chapter, I.O.D.E., bursary, clinical nursing; C. MacLeod, surgical nursing prize awarded by Soroptimist Club. The

prize for second-year students in public health, given by the public health nurses, was won by Miss Bennett.

About three hundred guests attended the reception in honor of the graduates, given by the board of directors.

A dinner and dance was held by the Nurses' Hospital Aid in honor of the new class. L. Russell proposed the toast to the graduates, which was responded to by M. Beals. During dinner Mr. G. B. Macaulay played piano selections, while Mrs. C. Colpitts rendered a solo, accompanied by Mrs. A. J. MacDonald.

Those in charge of the event were: F. Breau, Mmes G. B. Macaulay (convener), J. Johnston, J. Innis, J. Morrell, and J. Barnett.

SAINT JOHN:

The Saint John Chapter were guests of St. Joseph's Hospital when B. Seaman was in the chair. Miss Seaman was appointed delegate to the N.B.A.R.N. annual meeting to be held in Edmundston in September.

Upwards of 350 attended the annual dance, held at the Admiral Beatty Hotel, under the auspices of the private duty section of the local chapter. Marie Wallace was the general convener of the committee in charge of arrangements, while E. Fullerton handled the tickets. The guests were received by Misses Wallace, M. Downing, section convener, and Mrs. E. T. K. Mooney. The dance was under the patronage of His Honor the Lieut. Governor and Mrs. MacLaren, His Worship Mayor E. W. Patterson, Dr. and Mrs. J. Tanzman, and Mr. and Mrs. R. H. Gale.

All proceeds went towards the nurses' registry.

The National Nurses' Memorial Service was well attended at Trinity Anglican Church and at the Cathedral.

General Hospital:

Ruth A. R. VanWart, of Kingston, N.B., who led the province in the nurses' R.N. exams, received the major prize at the graduation exercises of the General Hospital School for Nurses. This award was for general proficiency throughout the three-year course, presented by Dr. F. K. Stuart on behalf of the Medical Society.

Dr. D. C. Malcolm, vice-president, Board of Hospital Commissioners, was chairman and presented the diplomas to the fifty members of the class who received their pins from M. Murdoch, retired superintendent of nurses. The valedictorian was Lorna Wood who made the presentation of a bouquet of roses to Miss Murdoch on behalf of the new class.

The guest speaker was Mr. A. W. Carton, warden of the municipality. The Rev. C. W. Anderson offered the invocatory prayer and led the graduates in repeating the Nightingale Pledge.

B. Selfridge, alumnae president, presented to Helen Hume the association award for the highest theoretical standing in three years in the junior division. Prizes for highest standing in obstetrics were donated by the Women's

Hospital Aid and presented by the president, Mrs. E. R. Hagerman, to Marjorie Parker in the senior first division and Miss Wood, the valedictorian in the junior division. The superintendent of the hospital, Mr. R. H. Gale, presented to Isabel Baird the prize donated by the hospital honorary president, Dr. W. W. White, for highest standing in surgical nursing. Orma Smith, director of nurses, presented to June Hayes the prize established by a bequest of Ella T. McGaffigan for the graduate showing the greatest proficiency in bedside nursing.

Marjorie Parker and Louise Dewar came second and third in the provincial R.N. exams. Mrs. Fred Dunlop and daughter, Nancy, are at present touring Europe.

Lancaster Nurses' Association:

Pearl Byers, a bride-elect, was presented with a wall mirror by Sarah Miles, matron, on behalf of the association.

St. Joseph's Hospital:

Marie Wallace, the president, was in the chair at a recent alumnae meeting when a successful book shower was held for the student nurses' library. A food parcel was also prepared for the "adopted" English family.

ST. STEPHEN:

The home of Mrs. R. Rogers was the scene of the May meeting of St. Stephen Chapter when the president reported on the National Nurses' Memorial Service held on the first Sunday in May at Kirk-McColl United Church. The group included registered nurses, members of the staff and student nurses in uniform from Chipman Memorial Hospital. The sermon was preached by the Rev. B. D. Earle. Following the service the nurses enjoyed a sing-song in the vestry and a buffet lunch was served. H. Bartsch, superintendent, C.M.H., extended a vote of thanks to the Rev. Mr. Earle and to the committee for their hospitality to the nurses.

Mrs. C. Parks, convener for the recent food sale, reported that proceeds amounted to $73.14. Mrs. R. McCartney and B. Douglas were responsible for sending the overseas box for May while V. Graveson and R. Howe will look after it for July. It was decided to vote $25 towards participation in the St. Croix International Jubilee. A year's subscription to the *Journal* was given to each member of the C.M.H. graduating class as a gift from the chapter. A conclusion was reached to notify nurses that "all private duty nurses, employed on cases at C.M.H. for ten or more days in one year, are subject to regular registry fee."

Greta Black, of the General Hospital, Portland, Me., has accepted the position of assistant night supervisor at C.M.H. R. Parris, from the Bath Hospital, Me., is on the staff of C.M.H. for the summer. Mrs. H. Connick, who has been at the Red Cross Outpost Hospital, Plaster Rock, N.B., has returned home.

ONTARIO

DISTRICTS 2 AND 3

Brantford General Hospital:

The award of the Royal Red Cross (first class) to Edith M. Read was recently announced. A native of Medicine Hat and now a member of the Toronto public health service, Miss Read enlisted in 1939 with No. 15 C.G.H. and served overseas for six years. Her army travels took her to England, North Africa, and Italy. Prior to enlistment, Miss Read served as assistant superintendent of nurses here.

Miss Read was a member of the class of 1932, graduating at the top—a double medallist—and with the highest marks ever secured at B.G.H.

DISTRICT 5

TORONTO:

St. Michael's Hospital:

At a recent meeting of the alumnae association, Dr. R. T. Kelly, chief of ophthalmology, gave an instructive lecture on two common eye conditions—glaucoma and cataracts. His talk included a description of the anatomy and physiology of the eye, warning symptoms, medical and surgical treatment, etc.

Patricia Dennis was the winner of the alumnae scholarship for university study. Mary Shaver is health instructor at the school of nursing. Ann DesRoches has returned from Penetang and is now on the staff. Jean Robinson is at Shaughnessy Hospital, Vancouver. Florence Hinds is at St. Catharines General Hospital. Patricia Upshall is serving at Montreal General Hospital. Margaret Robertson is in charge of the outdoor department at Sunnybrook Military Hospital, Toronto, while Mary Rowland and Loretta Archambault are also there on the staff. Mary MacIntosh is working on her B.Sc. at St. Francis Xavier University, Antigonish, N.S. Helen Hyland, who is industrial nurse at Ault & Wiborg Co. of Canada Ltd., attended the convention of American Association of Industrial Nurses at Detroit.

Wellesley Hospital:

The following officers were elected at the annual meeting of the alumnae association: President, J. Hayden; vice-president, E. Fisher; recording secretary, M. Sewell; treasurer, H. Carruthers; custodian, B. Williams; Charity Fund, G. Bolton; social convener, A. MacLean.

Grace Bolton reported on the Charity Fund and the fund for boxes for nursery schools in England. Forty-five boxes have been sent, containing printed cotton, flannelette, wool, groceries, quilts, toys, etc. Thanks were extended to all graduates and their friends for their support in this project. Christmas boxes were sent to two graduates—Miss McMullen in England and Miss Whittaker in Ireland. Bessie Boyd now represents the alumnae on the Registry Council, replacing E. Fisher. Marie Sewell and Miss Bolton were delegates to the R.N.A.O. convention.

District 8

OTTAWA:

Civic Hospital:

The alumnae association recently held a successful 20th anniversary Spring Tea when the guests were received by the president, Evelyn Horsey, and Edith Young, director of nurses.

The members of the class of 1949 were guests at the May meeting when Mrs. James Thorn, wife of New Zealand's High Commissioner, was guest speaker.

Lady Stanley Institute Alumnae:

Although twenty-four years have passed since the Lady Stanley Institute ceased to function as a training school for nurses, a very active alumnae meets regularly.

Mrs. W. A. (Lyons) Cavan was hostess at the annual meeting when the executive was unanimously re-elected for another year. K. Pridmore, the president, was in the chair. The secretary, Mary Slinn, reported that seven meetings had been held during the past months with an average attendance of thirty. A balance of $365 was announced by the treasurer, M. Scott. A sale of home cooking last fall substantially added to the alumnae coffers. Some forms of service rendered by the alumnae included: Institute for the Blind, $25; towards financing a sick nurse's holiday, $50; membership fee for Blue Cross hospital care for charter alumnae member. Flowers were also sent to sick and bereaved members.

Last Armistice Day, Mrs. G. (Stewart) Bennett placed a poppy wreath at the Cenotaph. In February, fifty nurses, including Gertrude Garvin, an honorary member, and a number of out-of-town nurses gathered at the home of Mrs. J. (Pritchard) Howe to enjoy a social evening. Other hostesses during the year were: Mabel Stewart and Pearl Walker of the Royal Ottawa Sanatorium, K. Pridmore, M. Ralph, M. Scott, and Mmes A. (Bonell) Cram and W. A. (Manchester) Oliver.

District 10

FORT WILLIAM:

V. Weston presided at a regular meeting of District 10, held at McKellar Hospital, when interesting reports on the R.N.A.O. convention were read by D. Shaw and Miss Weston. They were thanked by J. Smart and A. Hunter. A committee, with Mrs. W. Geddes as convener, was chosen to prepare plans for entertaining the graduating classes of the three local hospitals.

QUEBEC

MONTREAL:

McGill School for Graduate Nurses:

Nurses who have attended the McGill School for Graduate Nurses are now serving in various capacities across Canada as follows:

B. Adams, G. Allen, W. Burwash—Child Welfare Association of Montreal; L. Miller,

V. Adair, V. Howard, M. Hollenbeck, H. Kennedy, L. Baldwin, E. Knutson, B. Mann, E. Shields, J. MacIntyre, M. Gibson—V.O.N.; D. Ball, E. Kirton, D. Morrison—Simcoe County (Ont.) health unit; E. McCready, E. McOuat—Kirkland Lake health unit; C. Dubé—Montreal City Health Department; D. Lemery—Metropolitan Health Committee, Vancouver; M. Lockhart—Bell Telephone Co., Montreal; Martina MacDonald—health service, Department of National Health and Welfare, Ottawa; M. MacNutt—P.E.I. Hospital, Charlottetown; N. Madden—Saskatchewan Department of Public Health; M. Ford—supervisor, Red Cross unit, Barachois, Gaspé; L. Wright—health unit, Red Deer, Alta.

M. Allen, M. Harling—teaching staff, Montreal General Hospital; G. Bailey—head nurse, Homoeopathic Hospital, Montreal; M. Barrett—training school office, Royal Victoria Hospital, Montreal; H. Batstone—ward supervisor, St. Paul's Hospital, Vancouver; Catherine Brown—University Hospital, Edmonton; H. Bryson—teaching staff, Homoeopathic Hospital, Montreal; C. Crowe—Alexandra Hospital, Montreal; M. Des-Rosiers, M. Harford—St. Mary's Hospital, Montreal; L. Ellard—Calgary General Hospital; V. Geer, E. Minty, B. Larster—Toronto General Hospital; C. Golightly—Shaughnessy Hospital, Vancouver; M. Graham—educational director, Children's Hospital School of Nursing, Halifax; A. Major—clinical supervisor, Montreal Neurological Institute; M. Morrison—City Hospital, Sydney, N.S.; E. Pepper—nursing division, D.V.A., Ottawa; V. Protti—clinical supervisor, Edmonton General Hospital; L. Reckenmacher—science instructor, St. Paul's Hospital, Saskatoon; E. B. Rogers—director of nursing, St. Catharines General Hospital; M. Rooney—clinical

and science instructor, Royal Alexandra Hospital, Edmonton; E. Rossiter—matron, Shaughnessy Hospital, Vancouver; V. Smalley—nursing arts instructor, Wellesley Hospital, Toronto.

A. Swenseid—Regina General Hospital; E. Honey—educational director, D.V.A., Montreal; Ruth MacDonald—Montreal General Hospital; J. MacGregor—teaching staff, Royal Jubilee Hospital, Victoria; Margaret MacLean—Toronto Western Hospital; S. Tretiak—Tuberculosis Hospital, Halifax; M. Tullis—O.R., Ottawa Civic Hospital; Grace White—Department of Health and Welfare, Kelowna, B.C.; F. Bergeron—clinical instructor, Notre-Dame Hospital, Montreal; M. McRae—Royal Victoria Montreal Maternity Hospital; P. Pike—clinical instructor, Allan Memorial Institute, Montreal; M. Pinchbeck—associate director, School of Nursing, McMaster University.

Claire MacDonald is studying for her B.Sc. at St. Francis Xavier University, Antigonish. E. Pibus is assistant superintendent, V.O.N., Montreal, A. Gage replacing her as supervisor, V.O.N. north district, Montreal. M. McKillop is carrying on a teaching program at the Royal Edward Laurentian Hospital, Montreal, while H. MacLaggan is on the staff at the same institution. A. Christie, who joined the night staff of the Montreal General Hospital during the past winter, is making plans to leave for New Zealand in the fall.

SASKATCHEWAN

Qu'Appelle Valley:

The new executive of Qu'Appelle Valley Chapter includes: President, S. MacKinnon; vice-president, M. Diederichs; secretary, Mrs. F. Upex. Dr. Jenner, recently appointed medical superintendent at Qu'Appelle Sanatorium, Fort San, and his wife, were guests at a chapter meeting when Dr. Jenner spoke.

Regina:

General Hospital:

The annual baccalaureate service for the 1949 graduating class was held at Carmichael United Church when the Rev. J. E. Lane gave the appropriate message of the evening.

Representatives from the hospital attended in uniform the National Nurses' Memorial Services held in May. The public health and private duty sections were also present.

Sixty-eight students received their pins and diplomas at the graduation exercises. Special prizes were awarded to the following: B. Lackey who received three prizes—the Dr. D. Lowe Memorial Medal for general proficiency; the Dr. Rodger Memorial Medal for first aid, and the pediatric nursing prize; P. Parker, surgical nursing; N. Hanson, medical nursing; M. Watson, obstetrical nursing; M. Gates, Nightingale award for devotion to duty. M. Watson gave the valedictory address. The guest speaker was Mr. Maurice Western, *Leader Post* editorial writer.

Grey Nuns' Hospital:

Dr. J. S. Thomson, president of the University of Saskatchewan, was the guest speaker at the 1949 graduation exercises. Martha Goski received the alumnae award of $200 while $100 from the Regina branch of the Catholic Graduate Nurses Association was given to Bernice Fay.

R. Dolan, of the O.R. staff, has resigned.

SASKATOON:

Agnes Macleod, director of nursing service with D.V.A., and chairman, Educational Policy Committee, C.N.A., was the speaker at a special meeting of the S.R.N.A. Miss Macleod gave an interesting talk on "Some of the Newer Trends in Nursing." This included information regarding the Metropolitan School of Nursing at Windsor.

City Hospital:

The guest speaker at a regular meeting of the alumnae was Mr. C. Hume, superintendent of the School for the Deaf. Later a social hour was held, with Mrs. J. E. Porteous and M. Jarvis presiding at the coffee urns. A gift of a satin-bound blanket and a corsage of red roses was presented to the president, Mrs. J. Tait, formerly M. R. Chisholm, by Mrs. S. K. Hayward on behalf of the members.

A member of the staff for a short period is Kathleen Scott, a graduate of the Redhill County Hospital, Middlesex, England, who is on leave of absence from the public health department of Hudderfield, Yorkshire.

St. Paul's Hospital:

A banquet and dance were held in honor of the 1949 graduates. The Bessborough Hotel was the scene of the alumnae dance, while a Mothers' Day Tea was given by the students in honor of their mothers. Three scholarships and special awards were given to the members of the class.

Saskatoon Sanatorium:

Helen (Rutherford) Willcox, a former member of the staff, now resides in Peterborough, Ont. Other resignations include: Jean Hughes to do private duty and Emma Lenzmann who has gone to Abbotsford, B.C.

Positions Vacant

• CANADIAN RED CROSS SOCIETY •

invites applications for Administrative and Staff positions in Hospital and Public Health Nursing Services for various parts of Canada.

The majority of opportunities are in Outpost Services in British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia. Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances.

For further particulars apply:

NATIONAL DIRECTOR, NURSING SERVICES, CANADIAN RED CROSS SOCIETY, 95 WELLESLEY ST., TORONTO 5, ONT.

Supt., capable of taking full charge of Lady Minto Hospital. Salary: $200 per mo. with maintenance. Duties to commence Aug. 1. Apply W. G. Martin, Chairman, Box 223, Cochrane, Ont.

Matron & Registered Nurses (3) for modern 20-bed hospital. Salary: $175 & $145 with full maintenance. Write or phone E. W. Groshong, Sec.-Mgr., Porcupine-Carragana Union Hospital, Porcupine Plain, Sask.

Supervisor for new Surgical Wing—3 floors, 16 beds on each. Head nurse covering each floor. **Educational Director & Science Instructor** for 250-bed hospital with 135 students. 5½ day wk. 1 mo. vacation with pay after 1 yr. service. Position open for Fall. Apply, stating qualifications, experience, salary expected, Grace Hospital, Winnipeg, Man.

Public Health Nurse. Duties to commence this summer. Present minimum salary: $1,900 per annum. Suitable adjustment made for experience. 4 wks. vacation. Car allowance $600 & car provided if necessary, or purchase financed. Apply Supervisor of Nurses, Prince Edward County Health Unit, Picton, Ont.

Registered Nurse as Supervisor 3:30 p.m.-11:30 p.m. Experience in Operating-Room essential. Apply, stating qualifications & salary expected, Director of Nursing, County General Hospital, Welland, Ont.

Graduate Nurses for General Duty in Operating-Room, Obstetrics, Children's Hospital & Medical & Surgical Nursing. Good salary. High Cost of Living Bonus & laundry. Apply Director of Nursing Service, Victoria Hospital, London, Ont.

Graduate Registered Nurses for Operating-Room & General Duty in Ophthalmology Dept. 44-hr. wk. 28 days annual vacation & all statutory holidays with pay. Superannuation plan. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

General Duty Nurses for 17-bed hospital. Starting gross salary: $155 per mo. 48-hr. wk. 1 mo. vacation with pay after 1 yr. service. Pleasant living conditions. Transportation paid by Hospital Board if employed for 6-mo. period. Apply A. J. Schmiedl, Sec.-Treas., Municipal Hospital, Elnora, Alta.

Graduate Nurses (2). 44-hr. wk. No broken shifts. 28 days holiday annually plus 10 statutory holidays. Cumulative sick leave 1½ days per mo. Commencing salary: $150 per mo. plus Cost of Living Bonus $10 per mo. Annual increases. Flat rate of $25 per mo. for full maintenance. Apply Matron, General Hospital, Princeton, B.C.

Hospital Supt. for 32-bed Winchester Memorial Hospital, situated in prosperous farming community short distance from Ottawa. Apply, stating date available, qualifications, experience & salary expected, Dr. W. M. Byers, Sec., Winchester, Ont.

Supt. of Nurses immediately. Pleasant working conditions, excellent living accommodation & attractive salary to right person. Apply, stating age, education & experience, Mrs. M. Armstrong, Essex County Sanatorium, Windsor, Ont.

Asst. Supt. for well-equipped 20-bed hospital. Some knowledge of X-ray helpful. Salary: $130 per mo. with full maintenance. 3 wks. vacation with pay plus statutory holidays. Up to 2 wks. sick leave with pay after 1 yr. service. Straight 8-hr. day, 6-day wk. Apply, giving full particulars, Mrs. B. H. Mason, Supt., Louise Marshall Hospital, Mt. Forest, Ont.

DIRECTOR OF NURSES

WANTED

for the

GUELPH GENERAL HOSPITAL, GUELPH, ONTARIO

Furnish full particulars, including references, to the

Chairman, Board of Commissioners.

Executive Secretary for Division on Health of Toronto Welfare Council. This is a senior position, involving planning for health services within a community organization agency. The general duties are: Under administrative direction to co-ordinate & stimulate the development of community health services; to make available professional consultation to the individual health agencies & to Welfare Council. *Qualifications:* Graduate in Public Health with executive experience and/or training in community organization or social service administration. Salary: $3,500-4,000 depending on qualifications. Apply Miss F. Philpott, Exec. Sec., Welfare Council of Toronto, 100 Adelaide St. W., Toronto 1, Ont.

Instructor of Nurses for 200-bed hospital with Training School of 80 student nurses. New nurses' home is being constructed, providing for up-to-date Teaching Unit. Apply Supt. of Nurses, Victoria Public Hospital, Fredericton, N.B.

Science Instructor for School of Nursing in Ontario with student enrolment of 79. One class enters each yr. Block system of lectures in force. 8-hr. day, 48-hr. wk. for students. Position open Sept. 1. For further information apply Director of Nursing, Civic Hospital, Peterborough, Ont.

Clinical Teaching Supervisor for 125-bed Pediatric Hospital. 8-hr. day, 6-day wk. 1 mo. vacation annually. Apply, stating qualifications & salary expected, Supt. of Nurses, Children's Hospital, Winnipeg, Man.

Floor Supervisor, 3-11 duty. 6-day wk. Should have Obstetrical experience. Apply Supt. of Nurses, General Hospital, Stratford, Ont.

Public Health Nurse for generalized public health work in York Township. Salary: $1,850 per annum plus $1.20 per wk. Cost of Living Bonus. Apply, stating age, experience, etc., Dr. W. E. Henry, Medical Officer of Health, 1043 Weston Rd., Toronto 9, Ont.

Graduate Nurses for General Duty for new 60-bed B.C. coast hospital, newly equipped. Located on coastal "Inland Passage" 150 miles north of Vancouver. Salary: $160 less $25 for board, room, laundry. 1 mo. annual vacation with pay. 8-hr. day, 6-day wk. Arrangements can be made to advance transportation via T.C.A. on the undertaking to remain on staff for minimum of 1 yr. & to reimburse hospital by monthly payments. Apply, giving age, qualifications, training school, etc., Matron, St. George's Hospital, Alert Bay, B.C.

Graduate Nurse to take charge of Treatment Room—Pneumothorax, aspirations, dental, eye, ear, nose & throat clinics. Some Operating-Room experience preferred. Full maintenance provided. Apply, stating salary expected & date available, Director of Nursing, Freeport Sanatorium, Kitchener, Ont.

Graduate, Registered Nurse with diploma in Public Health for Health Service in Public Schools by Sept. Full-time. Minimum salary: $2,000; maximum, $2,500. Reasonable allowance for experience. Apply, stating qualifications, experience, age & other particulars, H. J. A. Brown, Sec.-Treas., Board of Education, Sault Ste. Marie, Ont.

Registered Nurses for General Staff work on Rotation Service. Apply Supt., Shriners' Hospital for Crippled Children, 1529 Cedar Ave., Montreal 25, Que.

Registered Nurse for staff of new 10-bed hospital in growing mining town in Northern Manitoba. Salary: $180 per mo. to start, with increases at 6-mo. intervals. Board & room deduction $42 per mo. 8-hr. duty or more pay for 12 hrs. Opportunity to learn X-ray & laboratory work if interested. Transportation refunded after 6 mos. service. References required. For further information write Dr. C. B. Colquette, Supt., Snow Lake Hospital, Snow Lake, Man.

General Duty Nurses for 80-bed General Hospital. Salary: $120 per mo. (including pay for O.R. call & bonus) plus maintenance. Increase at end of 6 mos. to $125 & at end of 1 yr. to $130. 8-hr. day, 6-day wk. 2 wks. holiday with pay (3 wks. given at end of 2nd yr). Allowance for sick leave, hospitalization & statutory holidays. Additional $15 per mo. for 3:30 shift & $10 per mo. for 11:30 shift. Apply, stating qualifications & date available, Supt., Norfolk General Hospital, Simcoe, Ont.

Graduate Nurses (4) for General Duty in 40-bed General Hospital, Salmon Arm, B.C. Beautifully situated on arm of Shuswap Lake. Salary: $155 gross, less $30 maintenance. Excellent meals. Fare refunded after 6 mos. up to $25. 1 mo. holiday with pay after 1 yr. service. 11 statutory holidays. Tennis, bowling, swimming, fishing, boating, etc., now. Badminton, skiing, etc., in winter. Apply Miss M. Avery, Matron.

General Duty Nurses for 50-bed hospital. Salary: $135 per mo. plus maintenance. 8-hr. duty, 6-day wk. 2 wks. holiday per yr. Good living conditions. 80 miles from Saskatoon with good connections. Apply Supt. of Nurses, Union Hospital, Rosetown, Sask.

Supt. of Nurses for Fall Term for 140-bed General Hospital with Training School of 50 students. Apply, stating qualifications, experience, salary expected, Supt., Aberdeen Hospital, New Glasgow, N.S.

Supt. of Nurses for Yarmouth Training School (70 beds) (urgent). Full maintenance. State qualifications, experience, salary expected. Also **Instructor of Nurses** by Aug. 15. Apply Apply Mr. A. G. MacLellan, Beacon St., Yarmouth, N.S.

Graduate Registered Nurse Instructor for Training School of 75 students in 150-bed General Hospital. Gross salary commencing at $190 per mo. increasing to $220 per mo. 8-hr. day, 6-day wk. 1 mo. vacation annually. Apply, stating qualifications, post-graduate experience, age & religion, Administrator, General Hospital, Chatham, Ont.

Instructor (qualified) by Sept. 1. Apply Supt., City Hospital, Sydney, N.S.

Public Health Nurses for Northumberland-Durham Health Unit. Salary range: $1,800-2,500. Allowance for public health or other nursing experience in starting salary. Car provided or car allowance. Apply Dr. C. W. MacCharles, M.O.H., Cobourg, Ont.

Public Health Nurses for Victorian Order of Nurses, Toronto Branch. Minimum salary: $2,087. 1 mo. vacation after 1 yr. service. Allowance for sick leave. Pension. Initial uniform allowance. Apply Miss E. Cryderman, District Supt., V.O.N., 281 Sherbourne St., Toronto 2, Ont.

District Nurses in Province of Alberta. Rural service. Emergency treatment, preventive & maternity program. Furnished cottage, fuel, water supplied. Salary schedule: $1,920-2,400. Sick leave, annual vacation, pension. Present Cost of Living Bonus $19.50 per mo. Apply Acting Director, Nursing Division, Dept. of Public Health, Edmonton, Alta.

General Duty Nurses for Day and Night Duty in small hospital. Good salary. Apply Supt., Rosamond Memorial Hospital, Almonte, Ont.

Public Health Nurses (2) (qualified) for Generalized Service. Apply in writing, stating qualifications, age, experience, salary expected, etc. Medical Officer of Health, Health Dept., City of Kingston, Ont.

Graduate Nurses for General Duty in Operating-Room, Obstetrical Dept., Medical & Surgical Floors. Modern well-equipped 100-bed hospital, Minimum gross salary: $155 per mo. Apply St. Mary's Hospital, Camrose, Alta.

Graduate Nurses for completely modern West Coast hospital. Commencing salary: $160 per mo. less $25 for board, residence, laundry. $10 annual increment. 44-hr. wk. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. accumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Matron, General Hospital, Prince Rupert, B.C.

Registered Nurses for General Staff Duty—(Div. of T. B. Control, British Columbia): **Vancouver Unit**—Salary: $168 per mo. with increments over 5-yr. period (including current C.L.B.). No residence accommodation. **Tranquille Unit**—Salary: $174 per mo. with increments over 5-yr. period (including current C.L.B.). Attractive modern residence. Recreational facilities. Exhilarating climate. 8-hr. day, 5½-day wk. (Overtime paid when necessary.) Annual vacation, 1 mo. with pay & 11 statutory holidays. Sick leave, 14 days per yr. (cumulative) plus 6 days for incidental illness. Superannuation plan. Further information & applications may be obtained from Supt. of Nurses in respective Units or Director, T. B. Nursing, Vancouver, B.C.

General Duty Nurses for 350-bed Tuberculosis Hospital. Blue Cross hospitalization plan. For further information apply Miss C. L. Bartsch, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Graduate Nurses for Staff Positions with Victorian Order of Nurses, Toronto Branch. Minimum salary: $1,800. 1 mo. vacation with pay after 1 yr. service. Allowance for sick leave. Pension. Initial uniform allowance. Apply Miss E. Cryderman, District Supt., V.O.N., 281 Sherbourne St., Toronto 2, Ont.

Nursery Supervisor (experienced) for small Nursery Unit. Post-graduate course in Obstetrics & ability to teach students essential. Apply Director of Nursing, Civic Hospital, Peterborough, Ont.

Registered Nurses for General Staff in 20-bed hospital. Salary: $142.50 per mo. plus laundry & $15 bonus payable every 3 mos. 8-hr. day. Cumulative sick leave allowance, hospitalization plan. Permanent hospital under construction. Apply Supt., Oakville & District Temporary Hospital, Oakville, Ont.

General Staff Nurses, 44-hr. wk. Starting gross salary: $155. Registration in British Columbia essential. Apply Supt. of Nurses, Royal Columbian Hospital, New Westminster, B.C.

Registered Nurses (3) for new 12-bed hospital. Salary: $130 per mo. with everything found. Apply H. E. Corbett, Benito, Man.

Vancouver General Hospital requires **General Staff Nurses** for *vacation relief & permanent staff*. Salary: $172 gross, including current Cost of Living Bonus. Extra premium for evening or night duty. Registration in British Columbia required. For further information apply Director of Nursing, General Hospital, Vancouver, B.C.

Nursing Arts Instructor & Science Instructor to join teaching staff of 450-bed hospital immediately. No. of students, 150. Apply, stating qualifications, Principal, School of Nursing, General Hospital, Saint John, N.B.

Obstetrical Supervisor to take charge of 50-bed Maternity Dept. & teaching of Obstetrical Nursing. Post-graduate course as well as experience in Obstetrics preferred. Apply, stating qualifications, Director of Nursing, General Hospital, Saint John, N.B.

Nursing Arts Instructor, experienced Teaching Surgical Supervisor & Pediatric Supervisor immediately. Salary for ea. opening: $200 gross per mo. 4 wks. holiday with pay. 6 statutory holidays per yr. Apply, stating qualifications, Director of Nursing, General Hospital, Kingston, Ont.

Instructor for 140-bed hospital. Student enrolment, 45. Salary: $200 (includes everything but room). 5½-day wk. Apply c/o Box 7, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Night Supervisor for 180-bed hospital. 48-hr. wk., rotating 3-11, 11-7. 1 mo. vacation with pay. 21 days sick leave per annum with pay cumulative to 6 mos. Pension plan. Salary open, depending on qualifications & experience. Apply, stating when available, Supt. of Nurses, General Hospital, Moose Jaw, Sask.

Operating-Room Supervisor (experienced). Apply, stating qualifications & salary expected, Supt., Grace Hospital, St. John's, Newfoundland.

Operating-Room Nurse with post-graduate training. Basic salary: $190 per mo. gross, plus $10 for on call service. **General Duty Nurses.** Basic salary: $180 per mo. gross. Annual vacation: 28 days after 1 yr. 18 days sick time without pay deduction cumulative. 10 legal holidays. 8-hr. day. Annual increments: $10, 1st yr.; $5.00, 2nd yr.; $5.00, 3rd yr.; $5.00, 4th yr. Eligible for registration in B.C. Apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

General Duty Nurses for 65-bed Solarium for Crippled Children. Basic gross salary: $150. Rotating shifts. Room, board & uniform laundry provided at $25 deduction. The staff is housed in very modern, new 4- and 6-bed cottages on waterfront. Excellent opportunity for nurses to gain experience in Orthopedic & Pediatric nursing. Openings also for **Dietitian-Housekeeper, Physiotherapist & Lab. X-Ray Technician.** Apply in writing, giving date of graduation, training school, age & experience, Lady Supt., Queen Alexandra Solarium for Crippled Children, P.O. Cobble Hill, V.I., B.C.

General Duty Nurses for modern 50-bed hospital, 20 miles from Lake Huron. Salary: $115 per mo. plus maintenance. Increase at end of 6 mos. to $120 & at end of 1 yr. to $125. 8-hr. day, 6-day wk. 2 wks. holiday with pay. 3 wks. given at end of 2nd yr. Blue Cross hospitalization. Additional $5.00 per mo. for 3:30 shift. Apply, stating qualifications, date available, Matron, Scott Memorial Hospital, Seaforth, Ont.

Floor Duty Nurse. 8-hr. duty. Salary: $110. Full maintenance & laundry. Blue Cross hospitalization. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

Graduate Nurse to administer Streptomycin & take charge of dressings. Also **Graduates for Supervisory position & Floor Duty.** Apply Director of Nursing, Freeport Sanatorium, Kitchener, Ont.

General Duty Nurses. 8-hr. broken day. 48-hr. wk. Gross salary: $163.40 monthly. All salaries have scheduled rate of increase. Cumulative sick leave. Pension plan in force. Blue Cross plan. 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.

Graduate General Duty Nurses for small 15-bed hospital in town of about 1,000. Good railway & bus service to city. Salary: $135 per mo. Full maintenance. 8-hr. day, 6-day wk. 1 mo. holiday with pay after 1 yr. service. Apply Jas. J. Hewitt, Sec., Union Hospital, Grenfell, Sask.

Night Supervisor. Must be Registered Nurse with hospital experience. For Aug. 1 at General Hospital, Guelph, Ont. Also **Asst. Night Supervisor.** Apply, stating experience, giving references & salary expected, to Supt.

Director of Nurses for Royal Columbian Hospital, New Westminster, B.C. Nearly completed addition to hospital brings total bed capacity to approx. 412. New Westminster, a thriving city with pop. of about 34,000, is located 12 miles from Vancouver. Duties consist of directing Nursing Services & accredited School of Nursing with approx. 140 students. Teaching degree & administrative experience required. Apply, giving full details of age, education, training, experience & salary expected, to Director of hospital. (Applications must be received not later than *July 25.*)

Nursing Arts Instructor with degree, **Operating-Room Supervisor & Nurses for Obstetrical Dept.** for 154-bed hospital connected with large clinic, located in the Capitol City. Apply Director of Nurses, Evangelical Hospital, 6th & Thayer, Bismarck, North Dakota.

Graduate Nurses (3) for permanent staff for new 25-bed hospital—2 to commence July 8 or 15 and one on Aug. 1. Salary: $125 per mo. & full maintenance, with an increase after 1 yr. service. Half of transportation refunded after 6 mos. service & balance after 1 yr. For further particulars apply or wire collect Miss A. P. Dow, Matron, Municipal Hospital, Two Hills, Alta.

Science Instructor for General Hospital, Hamilton, Ont. 900 beds & 300 student nurses. Apply C. E. Brewster, Supt. of Nurses.

Nursing Arts Instructor—Gross salary: $195. **Science Instructor**—Gross salary: $205 less $30 maintenance per mo. **Clinical Supervisor**—Gross salary: $180 less $30 maintenance per mo. 188-bed hospital. 44-hr. wk. Apply, stating qualifications & experience, Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Asst. Day Operating-Room Supervisor & Night Obstetrical Supervisor for 200-bed General Hospital. Apply Director of Nursing, Greater Niagara General Hospital, Niagara Falls, Ont.

Graduate Nurses for General Duty. Gross salary: $171 with bonus of $5.00 when registered in British Columbia. Annual increments. Statutory holidays. Good living accommodation & cafeteria service at reasonable cost. Apply Supt. of Nurses, West Coast Hospital, Port Alberni, V.I., B.C.

Registered Nurses for Sunnybrook & Westminster Hospitals, Toronto & London, Ont. Salary: $1,920-2,220 & $2,160-2,460 plus material for uniform. Information & application forms available at Post Offices or Civil Service of Canada, 1207 Bay St., Toronto 5, Ont., & the latter should be filed at this address as soon as possible.

Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. 8-hr. day, 6-day wk. Gross salary: $150-160 per mo. plus laundry & meals when on duty. For further information apply C. E. Brewster, Supt. of Nurses.

Public Health Nurse for City of Owen Sound. Salary equivalent to any in larger centres, plus car allowance. Apply M. S. Leslie, City Hall, Owen Sound, Ont.

General Duty Nurses for modern 25-bed hospital. Salary: $130 with full maintenance. $5.00 increase after 6 mos. 8-hr. day, 6-day wk. Permanent night nurse on staff. 3 wks. holiday with pay after 1 yr. service. 50 miles north of Calgary with excellent train & bus service. Apply Matron, Municipal Hospital, Didsbury, Alta.

Detergents

This seems the right moment to discuss some of the new cleansing agents now on the market and their relation to the spread of disease. These new substances, referred to as "detergents," "synthetic detergents," or "soapless soaps," are available under a variety of trade names. Although the word "detergent" means a cleansing substance and

includes soap, water, and other types of cleansers, the group of products to which the term "detergent" is applied commercially has its own special characteristics.

The first so-called detergent, "Gardinol," a wetting and cleansing substance with coconut oil as a base, was manufactured in Germany in 1925, and was brought to the United States about 1930 by the Allied Chemical and Dye Corporation of New York. Today, about 2,000 varieties of detergents are available, made mainly from vegetable oils and petroleum derivatives, through a complicated chemical process, by leading chemical and soap companies.

These products are usually put out in granular form for dishwashing and laundering and in liquid form for shampoos, although a liquid detergent for household use has appeared on the market within the last year.

Detergents, usually more complex products than soaps, possess some of the same properties—solubility in water, for example, and cleansing action. They are high in wetting power which enables the cleanser to penetrate the surface of the article more effectively. Most of them work up a thick billow of suds but a few are nonsudsing. The latter are useful mostly in automatic washing machines where suds interfere with the mechanical operation of the machine. So far, this type has not been widely distributed.

Unlike soap, they work just as well in hard water and salt water as they do in soft water. Water hardness interferes with cleansing by reducing the active cleansing content of the solution. Since detergents act more efficiently in hard water than soaps do, less detergent than soap is required.

Water hardness also is responsible for the curd or scum formed when soap is used — the cause of the streaks sometimes left on dishes after washing. A good detergent eliminates this unpleasant feature. With the aid of a good detergent, dishes can be washed, rinsed, and left to dry without wiping — and come out of it with a "sparkle."

While it is not expected that these new chemical compounds will replace soap, they are being widely promoted for a variety of uses. Their performance with delicate fabrics is unusually effective, and they cleanse woolens in one-sixth of the time that soap does. They are about equal for silk and rayon, and inferior for cottons, especially heavy, badly soiled cottons like workmen's overalls. They may be preferable to most soaps for baby clothes and diapers because they do not leave a deposit that may irritate the baby's skin. Since they do not streak, they are good for washing windows, mirrors, and similar shiny surfaces.

Will detergents prove to be powerful instruments against the spread of disease? That is the most interesting possibility they hold out. As efficient cleansers some of them are already making a contribution in this respect. They encourage cleanliness because they make cleaning easier and quicker. Some of them are capable of removing the greasy residue of food, breeding grounds for bacteria, from eating utensils, and they do not leave a residue of their own.

Extensive experiments conducted by the U.S. Army have demonstrated the vast importance of inadequately cleaned eating utensils in the spread of disease. If detergents are bacteria destroyers, the problems of sanitation in public eating and drinking establishments can be greatly reduced.

Proof of their bactericidal qualities is not readily obtained. Detergents vary greatly in composition and effectiveness. Several interesting experiments have been conducted in order to set up criteria for evaluating them.

The whole subject of detergents raises important questions, many of which can be answered only after extensive scientific investigation. Where are detergents likely to take us in the field of communicable disease nursing? Will they revolutionize our techniques? How can we use them to the best advantage in the light of our present knowledge? In time we may be able to eliminate boiling dishes and linen. Detergents seem to have some advantages for washing dishes and certain fabrics, especially in hard water areas, because of their strong cleansing properties. The use for which the detergent is intended, and instructions for its use, appear on the package. By reading these directions carefully, you can find out whether the product is appropriate for the purpose you have in mind.

Some persons may develop skin allergies from using certain detergents and so it is well to try out the product before making prolonged use of it.

— *M.L.I.C. Quarterly Bulletin*

Obstacles are those frightful things you see when you take your eyes off the goal.

—HANNAH MORE